

ABSTRACT

An evaluation of group counselling as a therapeutic intervention for patients suffering from a chronic illness is presented. The research design incorporates scientific and new paradigm methodologies, the scientific methodology generates quantitative results and the new paradigm methodology generates qualitative results.

A sample of thirty patients suffering from rheumatoid arthritis were given a number of clinical and psychological tests. The patients were then divided into three equal groups. Two groups met weekly for six months for group counselling whilst the third group acted as a control. Upon termination the clinical and psychological tests were re-administered and a quantitative analysis of the results made. The qualitative analysis was made by triangulation and respondent validation from video recordings, conversations with counsellors and patients, observations and written comments.

The quantitative and qualitative results are different. The quantitative results show that the group counselling made no difference to the patients, but the qualitative results show that the group counselling was a therapeutic intervention. It is argued, in conclusion, that the qualitative results should be accepted as the accurate evaluation and the quantitative results rejected.

An Evaluation of Group Counselling as a
Therapeutic Intervention for Patients
Suffering From a Chronic Illness
with Special Reference to
Rheumatoid Arthritis.

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Closely following Ruby and Judith are the patients who were courageous in volunteering to take part. Little was known of the effects of group counselling for patients suffering from a chronic illness and they ran the risk of being guinea pigs. The research demanded a large amount of their time and frequently involved their families. Once committed to the project the patients gave of their time generously. They attended regularly despite the fact that they were often in pain or suffering the debilitating tiredness of rheumatoid arthritis. They participated with enthusiasm and determination. Their optimism and cheerfulness was



remarkable given their disease. Unfortunately they must remain anonymous.

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all patiently, calmly, reliably and efficiently. Her personal support was invaluable.

INTRODUCTION

People are the subject of this research thesis. The research seeks to understand them in their complexities, contradictions, weaknesses and strengths. Its emphasis is upon the completeness and wholeness of the individual. For such a diverse research topic no one academic discipline can adequately deal with the depth and breadth of the necessary analysis. Consequently, the research uses the tools and techniques of many academic disciplines in the context of group counselling to investigate the complexities of chronic illness behaviour associated with rheumatoid arthritis.

The focus of the research is people as individuals and the aim is a comprehensive understanding of their behaviour whilst coping with the chronic illness of rheumatoid arthritis; these are the strengths of the research. Conversely, the weakness of the research is that it cannot encompass all of the tools, techniques and knowledge of the various academic disciplines that it seeks to utilise. In this respect the thesis may not satisfy the expectations of any one academic specialist. Many fascinating and fruitful lines of inquiry were not pursued and inevitably these will leave the subject specialist frustrated. However, it is hoped that these omissions are compensated for by the overall comprehensiveness and understanding that it brings to human behaviour whilst suffering from a chronic illness.

'To yield to every whim of curiosity, and to

allow our passion for inquiry to be restrained by nothing but the limits of our ability, this shows an eagerness of mind not unbecoming to scholarship. But it is wisdom that has the merit of selecting, from among the innumerable problems which present themselves, those whose solution is important to mankind.' (Kant)

It is hoped that wisdom is presented in this thesis. That hope is one of the main concerns of some contemporary academic specialists. Those specialists seek to bring together diverse disciplines that contrast and illuminate differences that will hopefully contribute to a more thorough and rigorous explanation of chronic illness behaviour.

It is possible in other areas of research to have complete control over the subjects. This is particularly so in the field of physical sciences where human behaviour would be broken down so that only a particular aspect would be investigated. In this research the aim is to illuminate human behaviour and how it is affected by a chronic illness. It is difficult to limit the analysis to one particular aspect and this gives rise to the multi-disciplined approach adopted in this study.

The research is an evaluation of group counselling for patients with the chronic illness of rheumatoid arthritis and part of the evaluation is undertaken by the patients. When the subjects of the research are responsible for evaluating the outcomes then their assessments must be given proper attention. In

addition, where the subjects of the research have not been trained in using the analytical concepts of academic disciplines it is difficult to express outcomes in an academic language. These problems are described and solved in the thesis.

Part 1 of the thesis reviews the theoretical background to the research. There are four main theoretical areas which are described in different chapters. Chapter 1 investigates the definition of rheumatoid arthritis and describes it within the context of the classification of diseases. The chapter argues that the current definition of rheumatoid arthritis is unsatisfactory because it does not define a clear or concise disease.

Given the definition as stated in the medical literature, Chapter 2 investigates the psychological concomitants associated with the disease of rheumatoid arthritis. It describes those psychological concomitants and argues that there is a need for a therapeutic intervention to help patients cope.

Chapter 3 suggests that group counselling is a suitable therapeutic intervention to help patients cope. The chapter notes that group counselling can be based upon one of three main psychological theories or an eclectic combination. The chapter investigates the three theories concentrating upon psychoanalytical, behavioural and humanistic forms of group counselling. It concludes that the most appropriate basis for the group counselling intervention is humanistic psychology.

Chapter 4 discusses the theoretical basis for

the research design. The chapter notes that there are two major theoretical approaches to research design; scientific and new paradigm. The scientific research methodology uses quantitative results to evaluate outcomes whilst new paradigm research methodologies uses qualitative results to illuminate outcomes. The chapter argues that a combination of both methodologies should be used in order that the evaluation includes both quantitative and qualitative results as their strengths complement each other.

Part 2 of the thesis describes how the research design was operationalised and evaluated. Chapter 5 gives an account of the field work. The counselling process is described and the four stages that the counselling went through are discussed. The four stages were ice-breaking and climate creation, information exchange, self-disclosure and enhanced self-esteem and self-concept. Chapter 6 discusses the evaluation of the group counselling. The scientific methodology provides the quantitative results and the new paradigm methodology provides the qualitative results. The two sets of results do not agree. The quantitative results show that the group counselling made no difference to this group of patients. The qualitative results however, do show that the group counselling was therapeutically effective. The chapter argues that the qualitative results should be accepted as the final conclusion.

This Introduction commenced with a statement that the aim of the research was to seek to understand people in their complexities, contradictions, weaknesses and strengths. Its emphasis was upon the completeness and wholeness of the individual and it was noted that no one academic discipline could adequately deal with the depth and breadth of the necessary analysis. These aims inevitably have consequences for my role as a researcher in the project. I saw my role primarily as that of a reporter, truthfully and accurately to record what took place. This sentiment has a directness and apparent openness that sounds attractive, yet it is naive and simplistic. I am subject to the complexities, contradictions, weaknesses and strengths of my own personality as much as the subjects of the research.

It is a tradition of new paradigm research that the researcher indicates what his personal values and theoretical orientation is in order that the reader can evaluate the researcher's role in the research process and assess his biases and prejudices. This procedure should also apply to scientific research yet it is not a tradition in that arena. Such a statement would be seen to weaken the scientific objectivity of the research. Arguments will be presented in Chapter 4 as to why the researcher should be taken into account as a variable in the research.

The normal route to a Ph.D. study would be after a first degree. A student would have accepted the constructs and concepts of an academic discipline and wished to complete further research work in that area. I

have not approached this piece of research in the same way. I did not go to university after school to obtain my first degree and I do not consider that I hold the constructs and concepts of any one academic discipline to the exclusion of others.

After leaving school I spent six years working in insurance and have a knowledge and understanding of the business world. I then worked as a teacher for sixteen years. My academic studies incorporated the philosophy, psychology and sociology of education, together with the theories of management as applied to education. My most recent period of academic study was during 1984-1985 when I was seconded to Durham University to study for a MA(Ed.) in Guidance and Counselling. What I learnt during that period added to what I regard as my developing eclecticism.

From the breadth and depth of this experience I came to the conclusion that no one theoretical approach provided an adequate explanation of human behaviour. I have tried to adopt a theoretical orientation based upon my developing eclecticism. This eclecticism focuses upon the individual and observes him in his singularity and uniqueness. This approach is adopted rather than using one theoretical orientation which inevitably presents a limited view.

It is evident from the subjects that I have studied that a pure science is missing. This is one of my weaknesses. No doubt there are many lines of inquiry that a scientist would have wished to follow that I have

omitted.

I wished to make a contribution to society and believed that group counselling would bring help to patients. Group counselling differs from other forms of therapy because it does not offer a solution, but rather an opportunity for patients' to regain control over their lives. I was motivated to leave my teaching job and salary and become a student living on a student's grant to conduct this research. It was an important decision for me and having made it it was equally important that I did it well. This thesis therefore carries a heavy personal investment. I hope it will be one of the significant achievements of my life and trust that it will withstand the test of time. I find poignant echoes in the statement of Ruskin in his book *Sesame and Lilies*.

'This is the best of me; for the rest I ate,
and drank, and slept, loved and hated, like
another; my life was as the vapour, and is not;
but this I saw and knew; this, if anything of
mine, is worth your memory.'

PART 1

Chapter 1

THE DEFINITION OF RHEUMATOID ARTHRITIS

INTRODUCTION

This chapter examines the concept of rheumatoid arthritis to establish the nature of the disease. Rheumatoid arthritis is a chronic disease and is included under the classification of rheumatic disorders. Despite the increase in understanding and knowledge of acute diseases and improvement of treatments, the importance of chronic disease remains prominent. The chapter gives a brief historical account of the development of the concept of rheumatoid arthritis as a disease and describes it within the context of the classification of rheumatic disorders. The development of nomenclature upon which the definition of rheumatoid arthritis rests is noted and the diagnostic criteria which establishes the condition is given. The chapter also includes some of the physical features that are associated with the disease. The psychological aspects connected with rheumatoid arthritis are described in Chapter 2.

This chapter having described the historical development of the classification of the disease will attempt to show that the classification is not scientific and there is considerable confusion and uncertainty regarding the concept of rheumatoid arthritis. The medical definitions of rheumatoid arthritis do not withstand rigorous scientific investigation and thus a semi-scientific

definition, it can be argued, does not permit a fully scientific response. The officially designated diagnostic criteria are similarly examined and found to be confused and wanting in scientific precision. This lack of scientific rigour makes the investigation of the disease take place in an academic vacuum which does not contain the kind of research methodology where the full consequence of 'rheumatoid arthritis' cannot be appreciated. It is concluded that the confusion and uncertainty connected with the concept of rheumatoid arthritis is one cause of stress and anxiety for the patients.

CLASSIFICATION OF DISEASES

The classification of diseases has been a subject of discussion and debate for some considerable time. One of the first attempts to define and classify illness in terms of discrete disease categories was by Thomas Sydenham in the seventeenth century (Sydenham, 1848). Sydenham believed in a natural order of diseases, similar to the patterns and hierarchies which were being imposed on plant species by botanists at that time. This later led physicians to attempt to do the same with diseases.

The attempt to define and classify a natural order of diseases that would withstand rigorous investigations has not been successful. The failure is a consequence of not being able to limit the number of diseases to a finite number or to retain the same definition for each disease entity indefinitely. The repeated alterations to the classification of diseases can be seen to reflect the

concerns of clinical medicine and medical research at any particular time and some of these changes have been useful and beneficial.

One solution to the above problem of classifying diseases was to base the definition according to the area of the body or the organ in which the disease occurred. Most medical textbooks have adopted this approach. Diseases affecting the digestive system are grouped together in one section, which is then subdivided into diseases of the stomach, the intestines, the liver etc. Diseases affecting a particular organ can then be classified according to pathology.

This approach to classification reflects the interests of the medical profession. Medicine was concerned with the identification of diseased individuals, the diagnosis of their disease and intervention to cure or alleviate the symptoms. It was a classification suited to the practice of curative rather than preventive medicine. By contrast, preventative medicine would have required a classification that identified the biological and social causes of diseases, as opposed to their pathological effects, on the normal functioning of the body (Black, 1985).

As medical science developed, an attempt was made to establish the same theoretical framework as had been developed for physical science. There was no attempt to include the psychological aspects of diseases within the theoretical framework as Chapter 2 will demonstrate. In order that classificatory control could be acquired over

diseases and a theoretical framework established they first had to be named. One of the first considerations of the International League Against Rheumatism was the establishment of classificatory framework and the influence of the physical sciences is apparent.

'Diseases, like butterflies or plants, however, have to be carefully examined and classified before they can be studied profitably, and this had not yet been done; rheumatoid arthritis, for instance, was the proud possessor of over forty different names in various countries, whilst some of the less common entities appeared to have none. Until this problem had been overcome rheumatologists in various countries were unable to pool their knowledge and experience.' (Copeman, 1967. p. 95)

In establishing the classificatory framework one of the more prevalent categories of chronic diseases was arthritis or rheumatism. The words 'arthritis' and 'rheumatism' are terms of common parlance, usually used without any clear idea of their clinical meaning or knowledge of their aetiology or pathogenesis. 'Arthritis' means simply inflammation of a joint. To this extent it is an acceptable term, but reveals little of the cause or type of joint inflammation. Arthritis is thus a definable term, although by itself an inadequate diagnostic label. Rheumatism has no precise clinical meaning and appears to be used as a generic name to cover all the rheumatic diseases, which can include arthritis. In the practice of medicine

rheumatic diseases come under the heading of rheumatology.

Rheumatology. is:

'A branch of medicine concerned with a heterogeneous group of diseases and disorders commonly affecting the locomotor system. They may arise from primary pathological processes in connective tissue structures, from disorders of their function, or as a manifestation of systemic disease. Their common denominator appears to be involvement of connective tissue. Although joints appear to be the main site of symptoms, the arthritis is only one component of a constitutional illness of considerable complexity.' (Scott, 1986, p. 3)

This definition of rheumatology is not very specific and obviously covers a wide range of diseases and disorders. Most medical definitions are associated with the aetiology, pathogenesis or treatment of the disease but as none of these are known in the case of rheumatism they cannot be included. In fact, a generic definition cannot be precise and may cause some confusion and uncertainty. The consequences will be discussed later.

Grouping the wide range of rheumatic diseases together at first appears to be meaningful, not only pathologically but also in terms of therapeutic treatments. However, this depends upon how far resemblances are pursued because there are important differences, both in the

pathogenesis of the various forms of arthritis and in the therapies that are considered appropriate for them. The definition does not identify the dimensions involved nor does it specify any clear classificatory boundaries.

Rheumatism is better understood through an examination of the specific diseases which come under the generic heading. Invariably they are disorders which affect the locomotor system, normally involving connective tissue, but can involve other systems e.g. ankylosing spondylitis, psoriatic arthritis, gout and polymyalgia rheumatica. The range of rheumatic disorders extends to some 200 conditions (Wood, 1986). For the purposes of this study only rheumatoid arthritis will be considered as the other diseases fall outside the scope of the study.

Similar problems to those encountered with the definitions of arthritis and rheumatism are found with the definition of rheumatoid arthritis. Much confusion and uncertainty surrounds the term. This confusion and uncertainty arises because there is not universal agreement regarding the dimensions or boundaries of the disease or whether it is a single disease or syndrome. The confusion and uncertainty is exacerbated by the absence of exact classificatory procedures.

'The difficulties are exacerbated because the empirical tradition in science tends to assume that there can be only one correct context, and it is not realised that taxonomy is a philosophical rather than a 'scientific' pursuit.' (Wood, 1986, p. 25)

A brief account of the development of the definition will

serve to illustrate why this confusion has arisen.

HISTORY AND DEFINITION OF RHEUMATOID ARTHRITIS

Palaeopathological evidence for the disease is scanty, recorded cases from ancient Egypt being few and of indeterminate authenticity (Bourke, 1967; Short, 1974; Steinbock, 1976; Buchanan and Murdoch, 1979; Rogers et al, 1981). The writings of Hippocrates and Celsus give no descriptions of rheumatoid arthritis comparable in clarity to that of gout. The absence of convincing early descriptions either in literature or in medical writings has raised the possibility that the disease is one of comparatively recent times (Hughes, 1979). It is interesting to note that respected medical specialists do indulge in fanciful ruminations. These romantic ruminations lead them to suggest that several important historical figures suffered from rheumatoid arthritis, amongst them Christopher Columbus and Mary, Queen of Scots (Copeman, 1964). One wonders whether this is the 'human face of science', as the claims cannot withstand examination because the evidence is not available. But perhaps these writers are trying to engender interest in the subject.

Credit for the first description of rheumatoid arthritis is usually given to Landre-Beavais in 1800. Further evidence was added by Brodie in 1819. During the later years of the 1870's the germ theory of disease and the theory of specific aetiology emerged in France and Germany (Ackerknecht, 1968). These theories became the means for constructing new concepts of disease and health, and remain

basic tenets for scientific medicine. With the practical success of treating infectious diseases, the germ theory and the specific aetiology theory became the principal way of understanding disease causation (Berliner and Salmon, 1980).

In 1859 Garrod proposed the name 'rheumatoid arthritis' to replace the many names that the disease was known by. In the classification of diseases it was not an exact identifier. Ideally defining terms should be nouns and should not include adjectives (Wood, 1986, p. 2). The terminology leads to confusion because the disease is classified not only as 'Rheumatoid Arthritis' but as 'Arthritis, Rheumatoid', as in the Index Medicus. It was not until 1922 that the British Ministry of Health adopted the term as the official designation. Such was the caution surrounding the description, the American Rheumatism Association withheld recognition until 1941 (Rodnan and Schumacher 1983). This hesitancy and confusion over the definition have surrounded the disease since it was first identified and can be traced back to the classificatory nosologies of diseases which were established in Sauvage's Nosologia Methodica of 1763 (Wood, 1986).

The hesitancy and confusion seems to centre around two separate but interrelated issues:

- 1) the definition of the disease

and

- 2) the diagnostic criteria.

These two issues will be considered separately.

THE DEFINITION OF RHEUMATOID ARTHRITIS

Unfortunately there is no one universally accepted

definition of rheumatoid arthritis.

'A major source of difficulty in descriptions of rheumatoid arthritis lies in the very definition of the disease.' (Popert 1984).p 4.

There are two main dimensions to this difficulty:

a) the constraints of language

and

b) different cultural approaches to medicine.

These dimensions will be considered in turn.

a) Constraints of Language

It is not possible to investigate the constraints of language without using language. This is readily appreciated if a person says and means something then tries to repeat the thought without using words (Wittgenstein, 1958). Wittgenstein argued that this phenomenon was uniquely characteristic of language. However the phenomenon applies to any set of analytical constructs. It is not possible to think about a mathematical statement then to repeat the thought without using mathematical concepts. Nor is it possible to see the Mona Lisa then think of it again without using line or colour. However language is central to our construction of reality. Wittgenstein emphasised the internal relations of words to one another rather than their pictorial reference to independent states of affairs. The view that developed out of Wittgenstein's discussion of "ordinary language" can be summarised:

'All knowledge is relative to one's perspective; there is no absolute point of view outside one's historical and cultural

situation, and neither pure sense data nor formal logic can provide an absolute foundation of knowledge. The character of one's knowledge, the categories according to which experience is formed, what is considered as reasonable, and so on, are all functions of the word games or world view one has inherited and in which one lives. A person never has independent access to reality. One can only look through the opaque spectacles of the cognitive apparatus of one's historically given world outlook. The belief that our particular constructed and filtered experience is the accurate and true description of reality is a projection (Polkinghorne. 1983, p.421).

Medical definitions depend upon medical language and medical concepts can only be examined by it. The ability to define medical knowledge through medical language is very powerful. Bacon altered the concept of science by emphasising the notion that knowledge is power. Most of the professions have defined their own language which they have sought to maintain control over and thereby ensured their continued expertise.

The medical profession have the power to control medical language but their actual ability to define rheumatoid arthritis is constrained by the vocabulary available. This constraint is a general limitation of language and it applies to all understanding and experience. There are various factors that determine how a language is

constrained. For example there are national differences between languages, so that they do not always translate into each other and this affects medicine (Beighton, 1981). The problem of classifying and naming rheumatological diseases had always been a source of dispute between medical scientists in the countries where they had been described and studied. One of the aims of the International League Against Rheumatism was to gain agreement regarding the naming and classification of rheumatic diseases (Copeman, 1967).

Different national languages have different vocabularies which represent unique perceptions of national experience. Eskimos have no words for emotions when they are socially isolated and solitary (Harre, 1985). The Mubti tribe have no words that differentiate between the sexes until they become parents. The Mubti's vocabulary limits their language because the only words relating to gender are 'mother' and 'father' (Turnbull, 1965). A national language represents a unique set of perceptions which constrains the expression of experience. This has important consequences for what can be regarded as a disease in one culture but not in another as will be seen shortly.

These national differences between languages affect the response to and the definition of rheumatology. Differences of definitions are found within Western countries. The following description of juvenile rheumatoid arthritis notes that the term does not have the same meaning in North America as it does in U.K.

'Rheumatology is beset by such difficulties as perennial transatlantic differences over the

significance of the term juvenile rheumatoid arthritis illustrate. In North America this label is used inclusively as a collective referring to a range of conditions that could be designated less ambiguously. British rheumatologists, on the other hand, tend to use the term distinctively, confining 'JRA' to the occurrence in juveniles of the same disease that is encountered more commonly in adults. Both senses, the connotative and the denotive, represent real and legitimate needs which should be met. However, to confuse the two and, what is worse, to use the identifier for a specific entity as a generic descriptor is surely unhelpful.' (Wood, 1986, p.21).

There are differences between Western countries because the shared language does not ensure that identical meanings are embodied within the concept of the same word (Nehemkis and Charter, 1984). The same word has different meanings depending upon the person using it (Foucault, 1967). The Mad Hatter says

"That word means just what I want it to mean."
(Carroll, 1986)

Individuals bring their own sets of understandings to common situations and experiences as Wittgenstein has described. Language does not represent a definitive or permanent set of concepts. The meanings of words are not

limited by their definitions. One of the main identifiers of rheumatoid arthritis pain is 'stabbing' but the definition is 'to wound with a pointed weapon'.

The national difference between languages have been influenced by the various historical developments of the different countries. The languages describe different patterns of human interaction and as such change over time. The first documented meaning of disease, in English, in 1330, was 'an absence of ease, uneasiness or discomfort' (O.E.D., 1897) The meaning of the word was a description of a particular physical state. This meaning changed in 1637 when Descartes expounded the dichotomy between 're cogitans' (mind, internal mentation) and 're extensa' (objective reality, the physical realm) (Wilson, 1969).

For Descartes the material world comprised objects assembled like a huge machine and operated by mechanical laws that could be explained in terms of the arrangements and movements of its parts. His outlook was mechanistic, materialist, and in as much that complex wholes were deemed to be understandable in terms of their constituent parts, analytical and reductionist. In his attempt to build a complete cosmology or natural science he extended this mechanistic view of matter to living organisms. He came to compare animals to clocks, composed of wheels and springs, and he later extended this analogy to man. His work however, was theoretical and not verified by experimentation.

'But unlike his Puritan colleagues Descartes shunned experiment with Jesuitical disdain, preferring to arrive at his conclusions by deducing them, like Euclid, from fundamental

axioms which had in turn been born from pure contemplation.' (Miller, 1982, p.295)

There was appropriate language development to accommodate the new ideas and concepts of Descartes.

In England, Hobbes explained all phenomena, including human behaviour, on formal and mechanical principles. He was a materialist and determinist who thought all human sensation could be explained in terms of motion in the brain (Rogow, 1987).

'The most influential for psychology of the great philosophers of the period was, however, John Locke, who quite consciously models the mental world on the physical. As there are atoms, compounds and laws of motion in the external world, so in the world of the mind there are, simple and complex ideas, and laws of the association of ideas.' (Cupitt, 1985, p. 63)

Locke believed that observation of the natural world could result in universal laws regarding its nature being formulated. Newton was to fulfil that function. He showed for the first time that a single law of nature accounted for the observed phenomena of motion. More importantly he showed that the law could be expressed mathematically. Newton's use of mathematics established an enormously powerful paradigm which has dominated western science. However some would argue that this paradigm was flawed from the beginning.

'And having proposed exact correlation as the criterion of truth, (Newton in his Principia) took care to see that exact correlation was presented,

whether or not it was properly achieved. Not the least part of the Principia's persuasiveness was its deliberate pretense to a degree of precision quite beyond its legitimate claim. If the Principia established the quantitative pattern of modern science, it equally suggested a less sublime truth - that no one can manipulate the fudge factor quite so effectively as the master mathematician himself.' (Westfall, 1973, pp. 751-752)

The validity of mathematical measurement will be further investigated in the section on humanistic psychology in Chapter 3.

The development of mathematical measurements were to be used in medicine. Sanctorious believed that measurement was important.

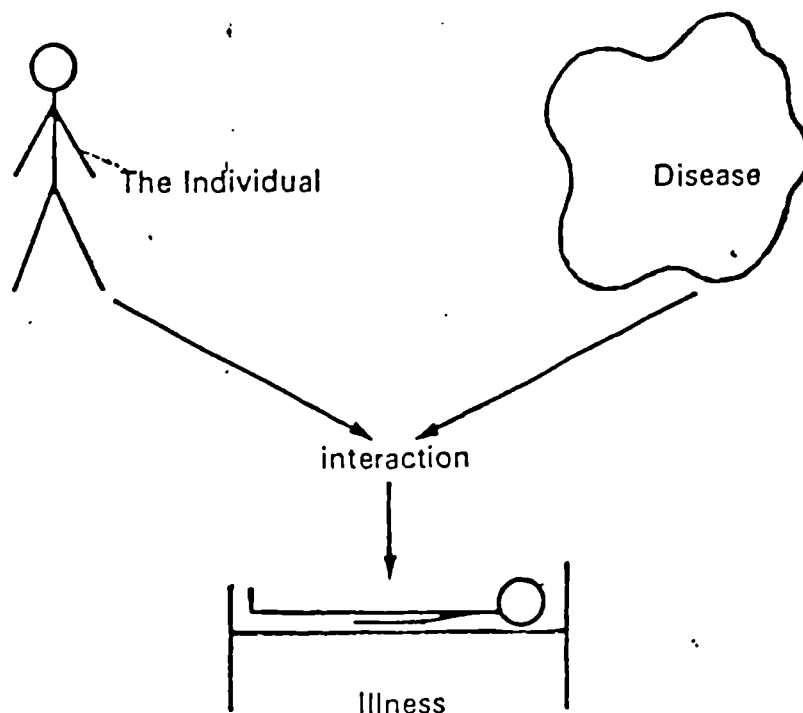
'He introduced into medicine the idea of reducing the events of physiology to mathematical terms and began the practice of counting the pulse, measuring the body temperature, and recording the weight of the body in varying circumstances.' (Mann, 1984, p. 240)

To Descartes the human body was a machine governed in principle by mathematical laws as mentioned above. Descartes did not identify mind with matter and considered that the study of mind could only be approached by introspective scrutiny of consciousness.

'The effect of this split was to bifurcate human experience into two distinct and discontinuous spheres: an objective world of

natural phenomena and an internal world of subjective sensation. Between the two, there opened a yawning chasm symbolised by the fateful dualisms of mind-body, object-subject, fact-value, and the knower and the known that have plagued modern sensibility' (Lucas, 1985 p165).

In medicine, the scientific 'body-object-fact' of Descartes's dichotomy became dominant. The effect was to allow internal states to be described as objective facts and to be made known to an observer. Language meant that internal states could pass outside the body and have external reality. Thus the meaning of disease no longer described an internal physical state but the language described the concept of an external autonomous and ontological entity.



Source - Copeman' Textbook of the Rheumatic Diseases

'Diagnostic reasoning is the process of converting observed evidence into the names of diseases. The evidence consists of data obtained from examining a patient; the diseases are conceptual medical entities that identify or explain abnormalities in the observed evidence' (Feinstein, 1973, p. 212).

In biomedical theory, disease became an abstract biological entity or condition that was generally speaking independent of social behaviour (Engel, 1977). This scientific development can be traced in medical history. Particularly important was the work of Sydenham:

'His careful studies of the effects of illness led him to consider diseases as entities. He was the first to clearly distinguish between the sick man and his illness. He described the manifestations and course of disease in detail, regarding the illness as a thing in itself.' (Taverner, 1968, p. 12).

The ideas of Descartes and Sydenham were supported by the work of Newton. Newton formulated the mathematical laws of mechanics which were thought to account for all the observable changes in the physical world. These laws lent support to the Cartesian notion of a mechanistic universe composed of particles of matter existing in space and time and impelled by force into motion or change of motion, created as such by God and set in motion at the beginning of time.

Two important developments were to flow from

Descartes' concepts. Firstly, the ontological definition of diseases allowed different nosological classification to be made. As such they became areas of medical specialisation which allowed a monopoly of knowledge to be gained and controlled by an expert. This expertise depended upon a body of knowledge being available through developments in language that the expert could lay claim to. This expertise led to the development of specialised clinics (Foucault (1973)). Clinics were the new arena which had evolved from the traditional way of practising medicine either in a hospital or in a patient's home. Secondly, the development had an effect upon medical education. Hippocrates had taken his pupils around the homes of his patients to teach them medicine. Now it became possible to learn about medicine by studying the diseases and not the people. Thus it was feasible for students to undergo training having very little contact with patients.

Sydenham was partly responsible for this development. Because of his interest in the classifications of diseases he did not place the same importance upon people. Sydenham was interested also in the environment.

'But we must return to Sydenham and to the ambiguity of what he had to teach us: in addition to being the initiator of classificatory thought, he defined what might be a historical and geographical consciousness of disease. Sydenham's constitution is not an autonomous nature, but the complex- a kind of temporary node- of a set of natural events: qualities of soil, climate, seasons, rain,

drought, centre of pestilence, famine; and when all these factors do not account for phenomena, there remains no clear species in the garden of disease, but an obscure nucleus, buried in the earth.' (Foucault, 1973).

Sydenham's historical and geographical consciousness of disease gave rise to the commonly held beliefs surrounding the various categories of arthritis, that it is associated with damp and cold. However, there is no scientific evidence to support such beliefs.

Sydenham was not the first to suggest that historical and geographical conditions had to be taken into account. It has been a central concern of medicine since Hippocrates. The Hippocratic treatise 'Airs, Waters and Places' was the first systematic treatment of environmental influences on health and for more than 2000 years was the basic epidemiological text (Phillips, 1973). It was this central concern that Sydenham was to develop.

The reason why Foucault mentioned the historical and geographical influences is because it was not tacitly mentioned by Sydenham. Environmental influences were to be submerged under the advance of biological medicine and were to remain covert, with the odd exception such as Snow and the Broad Street Water Pump Handle (Smith, 1979). The environmental aspects of health had to wait until the second half of the Twentieth Century to be taken seriously.

It has been argued above that language allowed the classification of disease categories to take place. The categories depend upon the symptoms being arranged in a

particular way. It soon became apparent that there was no limit to the number of different ways that a constant set of symptoms could be arranged. There was thus no restriction to the number of discrete disease categories that could be defined.

The development of medical science over the past four hundred years has seen an increase in the number of distinct disease entities from an almost constant set of symptoms (Illich, 1976). The increase in the number of disease categories does correlate with the increase in the size of the medical profession, however this does not prove cause and effect. Despite the development of these categories there was no logical necessity to call a set of physical symptoms a discrete disease (Kennedy, 1981).

In certain cases disease entities are no longer described by their pathologies. Disease, in the case of Briquet's syndrome, for example, is concerned with:

- a) a dramatic, vague or complicated medical history before the age of 30;
- b) at least 25 medically unexplained symptoms distributed in at least 9 out of 10 groups of abnormalities (Perley and Guze, 1962; Guze, 1970; Woodruff, 1971).

It is a strange irony that 'medically unexplained symptoms' can become diagnostic criterion.

This development has led to acerbic criticism of the medical profession:

'Diseases and physical mischiefs have been invented, and produced in the susceptible by medical intimidation.' (Comfort, 1967, p. 6).

This criticism provides an example that medicine cannot comply with the rigours of a physical science. Medical science lacks the rigid framework of the physical sciences. There are occasions when medicine stretches the imagination because of the lack of logic. Thus it was possible to make claims for bizarre syndromes such as 'restless legs' (Ekbohm, 1945, 1960; Cybulska and Rucinski, 1985; Gibb and Lees, 1986). The syndrome was supposed to affect one third of patients who already had rheumatoid arthritis (Reynolds et al, 1986).

'The restless legs syndrome is characterised by an unpleasant creeping sensation deep in the legs. Patients may find these symptoms difficult to describe- sensations are felt deep in the muscles or bones as if they were "crawling with ants" or full of "writhing worms" (Clough, 1987, p. 262).

It has been seen that language occupies a central position in medicine. The semantic requirements of medicine were extensive and different diseases required separate descriptive identifiers.

'As a thing identifiable and separate from the person who harboured it, disease had its own identity, ran its own course, had its own prognosis and had its own specific therapy.'

(Bean, 1981, p. 39)

These developments have required language to change. Because language was flexible to respond to these demands over time, it could cope with the delineation of new

diseases. The current classification of diseases does not represent a fixed set of concepts that have universal meaning. The practice of medicine has always been the subject of negotiation and compromise.

b) Different Cultural Approaches to Medicine

It has been noted that language affects the definitions, descriptions and concepts of disease. The linguistic expression was also affected by cultural influences. These influences had their base in value or belief systems:

'Every scientific discourse is based on a set of culture and ideology-bound metaphors, and has therefore to be read as metaphor, and not as an 'objective' transparent language that would stand in a one-to-one relationship with an immutable, absolute reality.' (Joris, 1980, p.750)

Western culture as a whole was conditioned to the rational, the logical, the linear and sequential, and to a description of a manifest, explicate reality. As a result the ability to 'think straight' was highly valued and there was a tendency to feel that primary experience was of that order (Bohm, 1980).

Cultural influences allowed certain symptoms to be legitimately described as a disease in one culture but not in another. The establishment of this fact led to the assertion that health was socially defined (Kelman, 1980). The Western World had an approach to medicine that was distinctly different from other

cultures and examples that support this assertion can be found (Fabrega, 1975).

'Osmidrosis axillae' is not regarded as a disease in the West but it is in the East. The Japanese were particularly conscious of it. The disease had as its main symptom body odour emanating from the armpits. The body odour was significant in Japan because only a small proportion of the population were of aniu descent. The aniu race belonged to the same ethnic group as Europeans and Africans. The Japanese regarded the condition as unpleasant and a disease. The disease was a legitimate cause for exemption from military service. Doctors specialised in the treatment of the condition and patients expected to undergo a period of hospitalisation (Baker, 1974).

'Dyschronic spirochaetosis' is another example. It was a condition which caused skin disfiguration. In South America nearly everybody in one tribe had the disease, but because they were in the majority they were regarded as normal. 'Dyschronic spirochaetosis' is acknowledged to be a serious disease, recognisable by the expert but the members of the tribe who did not have the disease were socially ostracised and excluded from being allowed to marry (Dubos, 1965).

It is not necessary to consider such diverse cultural examples to illustrate the point. The French seem to have much more trouble with their livers than the English do. It is hard to believe that the liver is so much more endangered in France than it is in England in spite of different drinking habits. It seems more reasonable to assume that the French interpret their symptoms in the light

of a national obsession about the liver and subconsciously interpret physical sensations in terms of the organ.

'Once an organ gains a hold on the collective imagination, its influence is almost invariably exaggerated, and a wide range of symptoms are explained in terms of it.'

(Miller, 1982, p. 43)

In a similar way the legitimization of medical knowledge is affected by factors within the same culture. The medical profession have a monopoly upon correct medical terminology and their definitions have legitimate validation. This terminology has legitimization even when at variance with common language (Segall and Roberts, 1980). When a majority of lay people use the word 'stomach' to identify a different part of the body from the majority of doctors their answers are described as 'wrong' (Boyle, 1970).

Cultural influences also determine how people with legitimate diseases are treated. It appears there is a difference between acute and chronic diseases. In Western societies patients who have acute diseases are cared for. As Parsons (1952) has argued, illness is a form of deviancy from which people are expected to recover quickly and society only has norms for dealing with acute diseases. Those who have chronic complaints do not fare so well and this dichotomy is reflected in the approach of the medical profession who are less interested in patients with chronic diseases (Becker and Geer, 1978). Chronic patients are expected to pass for normal where they can. Where this was

not possible they were expected to bear their burden without causing embarrassment to the able-bodied population and should preferably withdraw from public view to suffer their pain in private. The able-bodied population did not want to be required to acknowledge their pain (Freidson, 1965).

It is seen that cultural influences affect the legitimation, description and treatment of disease. Medical systems, like political or educational systems do not easily cross national boundaries. These differences can be readily identified in the different approaches to medicine between the East and the West, and perhaps more subtle differences can be identified between different western countries.

It is against this background that the discussion of rheumatoid arthritis is set.

Language affects the way in which the disease is described and regarded as an entity in itself. Such a process depends upon the subjective opinions of medical practitioners. The definition has been a subject of debate for many years and it is unlikely that the debate will suddenly cease.

The problem of the definition of rheumatoid arthritis is not clarified by the following statement appearing in a recognised clinical medical textbook:

'There is now sufficient clinical, epidemiological, pharmacological and immunogenetic evidence to demonstrate that rheumatoid arthritis is not a single disease. Rather the term describes a syndrome comprising a non-specific progressive chronic inflammatory symmetrical peripheral

polyarthrititis, seropositivity for serum IgM rheumatoid factor and juxta-articular erosive changes on joint X-ray (Capell et al, 1983, p68).

It is paradoxical that medicine, which seeks to adopt a scientific approach to the description of its subject, could start a definition with the term 'non-specific'. This imprecise use of language encourages the confusion that science wishes to avoid. It is apparent that the definition could only be understood by medical specialists because it is assumed that the reader will understand that 'progressive, chronic, inflammatory, symmetrical, peripheral' refers to the joints. This operational definition is criticised elsewhere in classical medical textbooks on rheumatology.

'Vagaries of terminology are encouraged by the widespread misconception in medicine that a text book type of description, one which amounts to an enumeration of characteristic features, constitutes a definition.' (Wood, 1986, p.24)

However, despite these criticisms the idea that rheumatoid arthritis is not a single disease entity does gain support from other sources.

'Further splitting of RA into clinical subgroups may occur in the near future.'
(Grennan, 1984, p. 36)

and

'Rheumatoid arthritis may not be one entity, but is probably a variety of different

diseases masquerading under the same hat.'

(Berry, 1983, p. 22)

The confusion and uncertainty of disease classification is further exacerbated by the disease title. As noted above the identifier was criticised because it contained the adjective 'rheumatoid'. Other medical experts state that 'rheumatoid' should be the noun: 'arthritis' being a secondary classification.

'Although arthritis is the most frequent and prominent manifestation this is a generalised disease involving many systems so that it should more correctly be termed rheumatoid disease. Incomplete forms are common, and these may present considerable problems of diagnosis.' (Barnes, 1980, p. 30)

It would seem that the disease and its diagnostic criteria have not been well thought out. Some of the confusion and uncertainty arise from the attempt by rheumatologists to define a disease without knowing what causes it or what its pathogenesis might be.

'The precise aetiology of rheumatoid arthritis which is better called rheumatoid disease since it usually involves more than the joints, is unknown.' (Bird 1986, p. 374)

and

'Thus rheumatoid arthritis should be called rheumatoid disease. There is evidence of widespread involvement of many organs and tissues and of a profound metabolic

disturbance.' (Capell et al., 1983, p. 72)

Another source of confusion in the Capell et al (1983) definition surrounds the use of the word syndrome. In medical vocabularies the word seems to have three different meanings.

1) syndrome is used to describe one disease which has more than one symptom.

'Syndrome is a term applied to a group of symptoms occurring together regularly and thus constituting a disease to which some particular name is given'

(Blacks, 1984, p. 862)

2) syndrome is used to describe a number of diseases which have some connecting link. This is the definition used by Capel et al (1983) where the word is used in a generic sense.

3) syndrome is used to describe a sub-set of a recognised disease. Such as example would be a sub-set coming under the generic definition of rheumatoid arthritis, such as Reiter's syndrome, Sjogren's syndrome or Bechet's syndrome:

'What really matters is the nature of what is being identified, and there seems to be little justification for still refering to the syndromes of Reiter and Bechet-both appear to be specific entities and therefore to downgrade them as syndromes perpetuates an unnecessary degree of uncertainty, as well as posing needless difficulties about whether the condition is present if, for example, all the

features of Reitier's triad are not observed.' (Wood, 1986, p.24)

Some weaknesses have been discussed regarding the definition of rheumatoid arthritis. These weaknesses exist despite the fact that much time has been spent upon the classification of diseases. This work still continues (Wood, 1986; Danner Clouser, 1985; Tristram Engelhardt, 1985). The classification of diseases is an academic and ontological study carried out invariably by specialists in academic or laboratory conditions and this represents a scientific approach to medicine.

Outside the academic arena the practice of medicine is different. In its practical setting the confusion and hesitancy noted above is reflected in the cultural norms. For example the practise of medicine does appear to have programmed into it the notion of 'a second opinion' and any diagnosis would be the subject of discussion and negotiation. There would seem to be little attempt to check out the accuracy of diagnosis. Where this is possible little emphasis would seem to attach to it. For example one of the more optimum circumstances for testing diagnosis would be autopsy. Yet autopsy is not an integral part of the practice of medicine. Two studies have shown that the accuracy of using definitions of diseases in diagnosis is approximately 50% (Cameron and McGoogan, 1981; Mercer and Talbot, 1985). The studies compared the evidence of disease found upon autopsy with that made whilst the patient was alive and only in half of the cases did autopsy confirm the original diagnosis. This reluctance to encourage

autopsy may mean that important features of the disease are being ignored.

'Cardiac involvement is rarely diagnosed in life. However, at post mortem examination several lesions may be seen. Rheumatoid nodules may be found in the endocardium, myocardium, or pericardium. The incidences of these lesions is uncertain. Minor evidence of pericarditis is found in approximately 40 per cent of patients coming to post mortem study. By contrast, pericarditis is rarely recognised in life although both effusion and constriction have been reported.' (Barnes, 1980, p. 42)

These criticisms apply to most uses of language. As mentioned above language has to describe and reflect a developing and changing culture and much of this change is scientific. Language appears to resist the unitary and fixed nature that science requires and instead it is plastic and flexible. It is not anticipated that this process of change and development will come to an end.

'Classification is a dynamic process which requires periodic review and revision of existing nomenclature. Change is to be expected, and even applauded, since it nearly always reflects important new information and concepts concerning pathophysiologic mechanisms of disease.' (Rodnan and Schumacher, 1983, p. 36)

DIAGNOSTIC CRITERIA

As was noted above the recognised designation of rheumatoid arthritis was not given until 1859, although the disease had been mentioned before that date. The disease could then be defined and discussed and that process is still going on. Much of the time has been spent in placing rheumatoid arthritis into the classification of rheumatic diseases. This has not been without its difficulties. As the disease process is so variable this tends to increase the confusion and uncertainty. The definition lacks precision and it can often superficially resemble other types of joint disease. The American Rheumatism Association established several sets of criteria for the diagnosis of rheumatoid arthritis. The criteria, at first rather crude, were refined in 1958 (Ropes et al, 1958). Further revisions have been carried out (Blumberg et al, 1964; Bennett and Burch, 1967).

'It should be understood, however, that these criteria were not developed for the bedside diagnosis of rheumatoid arthritis but rather to classify large groups of patients for inclusion in epidemiologic surveys, drug trials, and studies of the natural history of the disease. Therefore failure to meet an arbitrary set of criteria need not preclude the diagnosis of rheumatoid arthritis, especially in its early stages.' (Rodnan and Schumacher, 1983, p. 45)

Despite the fact that the criteria were not

developed for the diagnosis of rheumatoid arthritis, it is actually used for that purpose and can be found in standard textbooks. The other feature of the diagnostic criteria that is worthy of mention is its arbitrariness. One is left wondering what the difference between the diagnostic criteria and the actual disease is and whether they may be so far apart as to make comparison arbitrary and meaningless. Considering the amount of time spent upon the discussion of the definition it seems strange that the diagnostic criteria should be arbitrary. The extent to which the diagnostic criteria supports the definition is problematical and makes the hesitancy understandable.

This confusion and uncertainty makes an investigation of the diagnostic criteria appropriate. The diagnostic criteria of the American Rheumatism Association, which are internationally recognised are

- 1) Morning stiffness;
- 2) Pain on motion or tenderness in at least 1 joint (observed by a physician);
- 3) Swelling (soft tissue thickening or fluid, not bony overgrowth alone) in at least 1 joint (observed by a physician);
- 4) Swelling (observed by a physician) of at least one other joint (any interval free of joint symptoms between the 2 joint involvements may not be more than 3 months);
- 5) Symmetrical joint swelling (observed by a physician) with simultaneous involvement of the same joint on both sides of the body (bilateral involvement of the proximal interphalangeal,

metacarpophalangeal, or metatarsophalangeal joints is acceptable without absolute symmetry);

6) Subcutaneous nodules (observed by a physician) over bony prominences, on extensor surfaces, or in juxta-articular regions;

7) X-ray changes typical of rheumatoid arthritis (which must include at least bony decalcification localised to or most marked adjacent to the involved joints and not just degenerative changes). Degenerative changes do not exclude patients from any group classified as having rheumatoid arthritis;

8) Positive agglutination test;

9) Poor mucin precipitate from synovial fluid;

10) Characteristic changes in synovial membrane with three or more of the following: marked villous hypertrophy, proliferation of superficial synovial cells often with palisading, marked infiltration of chronic inflammatory cells with a tendency to form lymphoid nodules, deposition of compact fibrin either on the surface or interstitially and foci of cell necrosis;

11) Characteristic histological changes in nodules showing granulomatous foci with central zones of cell necrosis surrounded by proliferating fixed cells, peripheral fibrosis and chronic, often perivascular, inflammatory cell infiltrate.

In criteria 1-5 the joint signs must be continuous for six weeks unless a diagnosis of possible rheumatoid

arthritis is made when the situation is different as mentioned below.

There are 20 exclusion categories. (Rodnan and Schumacher, 1983)

Although these are the diagnostic symptoms of rheumatoid arthritis it is not necessary to have them for a diagnosis to be made. This substantiates the claims made previously that more than one disease may be involved. According to the American Rheumatism Association there are in fact four possible diagnostic categories.

1) Classical rheumatoid arthritis when seven of the above are present.

2) Definite rheumatoid arthritis when five of the above are present.

3) Probable rheumatoid arthritis when three of the above are present.

4) Possible rheumatoid arthritis is diagnosed when two of the following criteria are present and the total duration of joint symptoms must be at least 3 week:

- a) Morning stiffness
- b) Tenderness or pain on motion
- c) History or observation of joint swelling
- d) Subcutaneous nodules
- e) Raised ESR or CRP

It is argued that these criteria could only be described as arbitrary. Different time lengths are involved, together with different symptoms, in different combinations. There would also appear to be a lack of rigour if the

disease has 11 symptoms that only 7 are needed for classical, lowering to 2 for possible rheumatoid arthritis.

'Although the category of classical RA allows very accurate recognition of the individuals with typical RA, the definite and probable categories have proved to include many individuals with some other variety of joint disease. Of the eleven diagnostic criteria only nos. 6,7 & 8 carry a high degree of certainty if positive. Criterion No. 7 for radiological changes is by no means specific for RA.' (Popert, 1984, p.5)

These criticisms do meet with general agreement. A range of criticisms can be offered amongst which are the role of rheumatoid factor (No. 8) in the aetiology and pathogenesis of rheumatoid arthritis remains unclear (Walker et al., 1986). Since the aetiology of rheumatoid arthritis is not well understood definitive diagnostic criteria have remained elusive. None of the numerous manifestations of the disease are universal (Kellgren, 1968), and many may be manifestations of other rheumatic and non-rheumatic diseases (Rodnan et al, 1973; Weiner, 1977). In addition the diagnostic problem is sometimes complicated by the remitting nature of the disease which results in dramatic changes in clinical and other data (McCarthy, 1972)

These criticism do not lend support to either the definition or diagnosis of rheumatoid arthritis. The diagnostic criteria would appear to be weak. This kind of generalised list suggests a cookery book approach. Comparing this definition with definitions in the physical sciences

raises indisputable contrasts. Nowhere in the physical sciences are definitions given in such a vague and generalised manner.

All of the categories of rheumatoid arthritis are psychosomatic in the sense that there is an intercausal relationship between physical and psychological characteristics of the disease. The degree to which they are psychosomatic will be discussed later. Rheumatoid arthritis depends in the first instance upon patient self report and therefore upon the patient cognitively recognising the symptoms and seeking help.

'The effects of disease include two types of phenomena: changes in the sense of awareness and well-being, and bodily perceptions. By sense of awareness and well-being, one means general assessments by the person about his or her self and correlated general characteristics of his or her cognitive functions. Bodily perceptions are private, subjective experiences the person links to his or her body.' (Fabrega, 1981, p. 89)

None of the diagnostic criteria include the psychological concomitants of the disease.

The diagnostic criteria can be grouped under three headings. Numbers 1-6 depend upon self report or physician observation, 7 upon X-ray findings and 8-11 by serological testing. None of these tests are rigorously objective.

The first two criteria listed are morning stiffness and pain on motion or tenderness in at least 1

joint. Both are subjective and depend upon patient perception and self-report despite the fact that the pain or motion should be observable to a physician. In the case of morning stiffness patients are asked how long it lasts. The answers are highly variable depending on a number of factors, one being how often patients have been up during the previous night, insomnia being a characteristic of rheumatoid arthritis.

Patients sometime confuse stiffness with other phenomena. Attempts have been made to obtain objective measurements by machine. These objective measurements do not always correlate with the patient's rating. Patients can confuse pain and movement difficulty with stiffness. The subjectivity of what a patient will label as 'stiffness', or the doctor's criteria for determining whether or not there is 'pain' are issues that have not been adequately resolved (McCarthy, 1972; Genest, 1983). As a consequence some ratings which claim to be objective diagnose some patients as 'stiff' while they do not complain of it and conversely other patients as 'not stiff' when they maintain they are stiff (Wright, 1959; Ingpen and Kendall, 1968; Rhind et al, 1987).

Similar difficulties are encountered with pain as a diagnostic category. It is now generally accepted that a purely physiological explanation of pain does not satisfactorily account for the phenomenon. This aspect will be more fully discussed in the next chapter. Even within the medical model the issue of pain as a diagnostic criteria is not without conjecture. It can be shown that patients who do

not have pain can be diagnosed as having rheumatoid arthritis (Crown et al, 1975).

It is unlikely that a diagnosis of rheumatoid arthritis would be made on the evidence of X-rays alone. This is because different rheumatic disorders exhibit similar pathologic radiographic features. These features should be considered for their predictive value relative to the clinical condition being considered (Martel, 1981). There is still some controversy over the interpretation of X-rays.

'Even with "objective" criteria such as X ray findings, there was a very high inter-observer variation between clinicians with long experience in diagnostic and survey work.' (Christian, 1966, p. 109)

The third method of diagnostic criteria was evaluated by serological testing. There is no one universal method of testing. In common with the other diagnostic factors there is not total acceptance of the methodologies involved or of the interpretation of their findings.

'Serological testing by different methods or in different laboratories showed considerable disparities (Christian, 1966, p. 109)

and

'the various serological tests for RA are not highly correlated with one another. Nor are these serological tests entirely accurate; positive serologies can occur among persons without RA, and some RA patients can show negative serologies.' (Anderson et al, 1985, p. 362)

The different ways of assessing patients by the American Rheumatism Association diagnostic criteria have been investigated above. Many of the methods of assessment do not appear to give definitive answers to what appears to be a medically intractable problem.

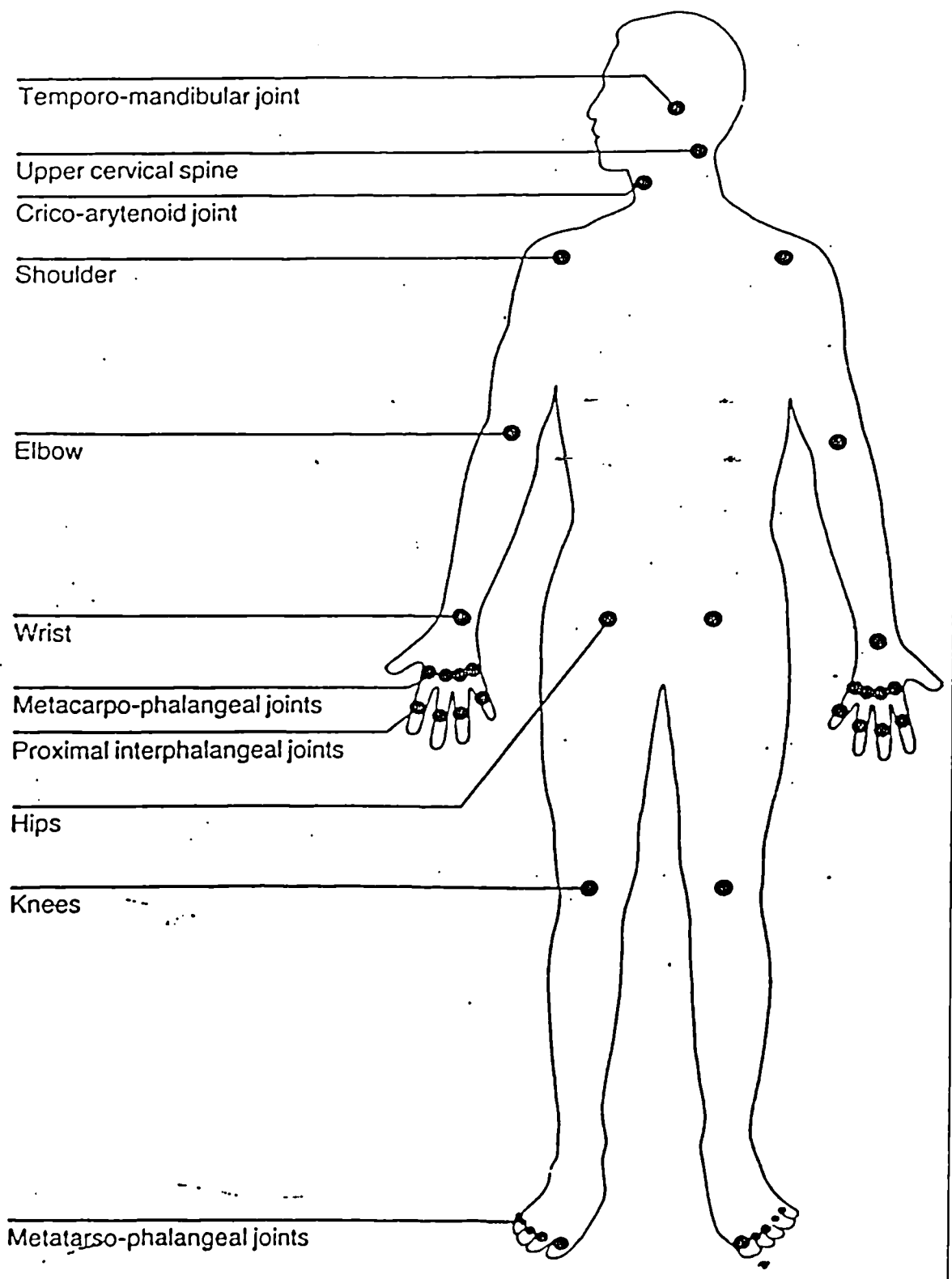
'The American Rheumatism Association criteria for the diagnosis of rheumatoid arthritis, are under seige at present and will require revision in the near future...' (Capell et al, 1983, p. 68)

Bean comments

'Because the concepts of disease change and the mental image of diseases shifts rather than stays fixed, traditional views are not always reliable or satisfactory. One is almost tempted to say that a change in concept produces a vacuum into which disease flow.' (Bean, 1981, p. 27)

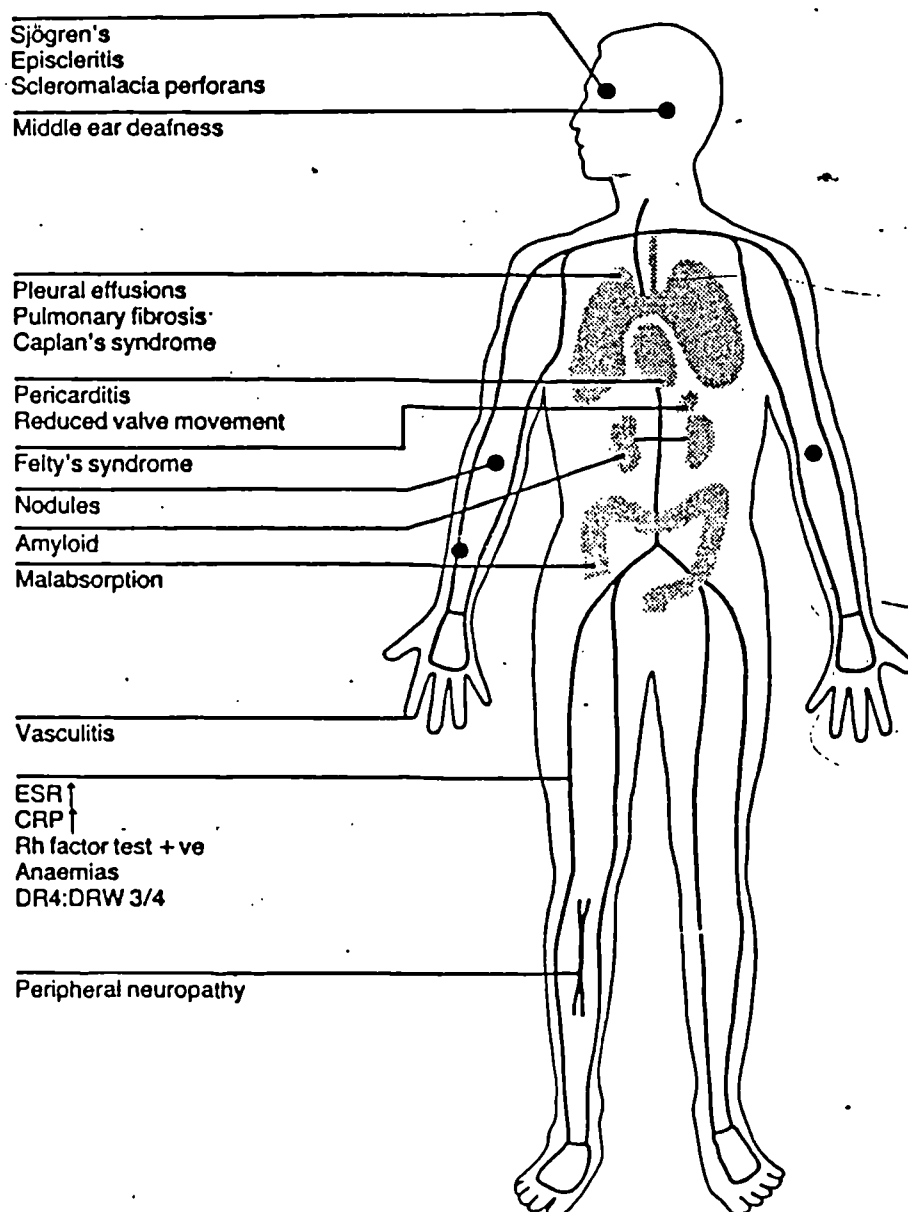
PHYSICAL IMPLICATIONS OF RHEUMATOID ARTHRITIS

Rheumatoid arthritis is the most common inflammatory polyarthrititis. It affects about 1% of the population (Wood, 1986). The condition can affect people of all ages and sexes, but is most common between the ages of 20-50. Women are affected more than men in the ratio of 3 : 1. Older men appear to be affected as frequently as older women and both sexes appear to be equally represented among those with more severe disease (Anderson et al, 1985). There are 187 joints in the body but they are not all affected. The following figure shows the distribution of joints involved.



Source - Copeman's Textbook of the Rheumatic Diseases

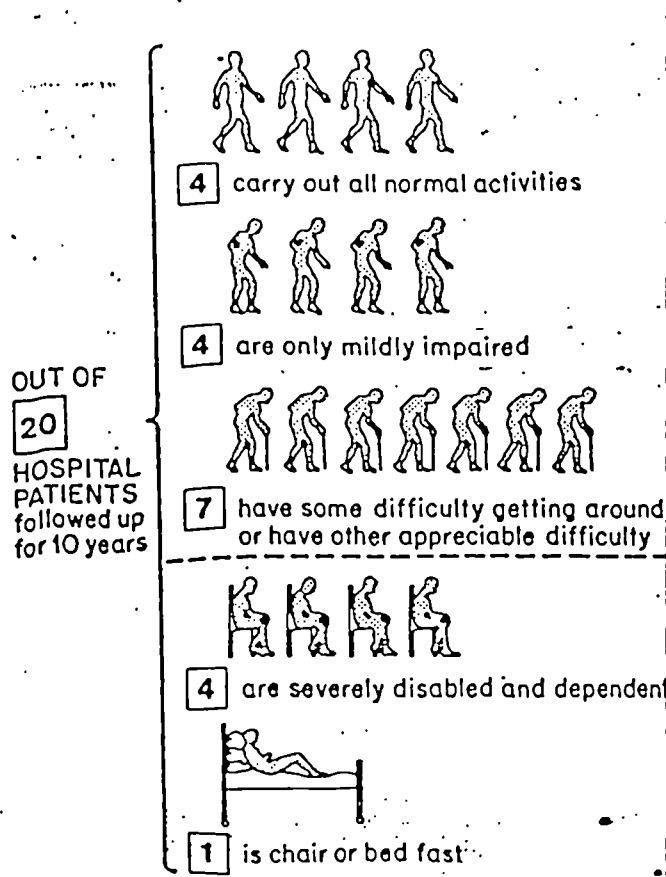
Rheumatoid arthritis can also affect other parts of the body. It is regarded as a multi-system disease although it was not clear from the Capel et al (1983) definition. The following figure illustrates the major sites that it can affect. It would appear that this involvement is secondary to the main diagnostic criteria.



Source - Copeman's Textbook of the Rheumatic Disease

As can be seen the disease can affect the major organs of the body. It can be life threatening although this is not typical. It is generally recognised that although the disease is not fatal, patients with rheumatoid arthritis do not live as long (Prior et al, 1984).

The actual number of people suffering from the disease is not known exactly. Patient numbers depend upon self referral and this is not the most effective way to calculate to exact size of the population. Some studies show that the system of self-referral is not very objective and people who have the disease do not report because another family member has been diagnosed and in comparison appears much worse (Walker, 1986). The following figure gives an example of prognosis.



Source - Copeman's Textbook of the Rheumatic Diseases

These different stages of the disease can be classified.

CLASSIFICATION OF PROGRESSION OF RHEUMATOID ARTHRITIS

Stage 1, Early

- 1) no destructive changes on X-ray examination
- 2) X-ray evidence of osteoporosis may be present

Stage 2, Moderate

- 1) X-ray evidence of osteoporosis, with or without slight subchondral bone destruction; slight cartilage destruction may be present.
- 2) no joint deformities, although limitation of joint mobility may be present
- 3) adjacent muscle atrophy
- 4) extraarticular soft tissue lesions, such as nodules and tenosynovitis may be present

Stage 3, Severe

- 1) X-ray evidence of cartilage and bone destruction, in addition to osteoporosis
- 2) joint deformity, such as subluxation, ulnar deviation, or hyperextension, without fibrous or bony ankylosis
- 3) extensive muscle atrophy
- 4) extraarticular soft tissue lesions, such as nodules and tenosynovitis may be present

Stage 4, Terminal

- 1) fibrous or bony ankylosis
- 2) criteria of stage 3 (Steinbrocker et al., 1949).

As has been noted rheumatoid arthritis is a disease

characterised by periods of exacerbation and remission. This process of fluctuation involves continual reassessment by the physician as the patient can move between these 4 stages. This process of reassessment provides another example of the wide variation that can occur between physicians' opinions which has been verified experimentally. In a series of investigations where physicians assessed the stage of a patient's disease it was found that they used three criteria only and that they were not always the same three (Kirwan et al., 1983 b). The three were taken from a list of 15 criteria that were not all included on the diagnostic list of the American Rheumatism Association (Kirwan et al., 1983 a). The physicians differed markedly on their assessment of the progress of disease with serious disagreements even when only clinically important changes were considered (Kirwan et al, 1984). Perhaps this confusion is a consequence of the unsatisfactory definition of rheumatoid arthritis.

The diagnosis of rheumatoid arthritis does bring considerable personal change for the patients and they have increased susceptibility to infection (Baum, 1971). If the degree of physical disability does not appear to be serious it is soon realised that it is not a passing phenomenon and some sort of reconciliation with the uncertainty in outlook has to be made (Wiener, 1975). Performance becomes impaired, personal habits have to change, and relationships with others have to be modified. In these altered circumstances things that were done without thought call for deliberation and things that were done easily become difficult or impossible. The patient has to search for

qualities to cope with the challenge of a chronic disease. These developments affect self image, which may be vulnerable to physical deformity and the patient's sense of identity can change.

Against this background it is evident that the individual is likely to be concerned much more with the consequences of his illness than with the actual illness itself. It is also clear that, unless a dramatic cure can be effected, contact with a physician and health care system are likely to play only a minor part in the changes the patient makes. As the patient strives to gain a realistic view of his situation he is likely to be considerably influenced by the views of other patients (Wood, 1986). The stress of these severe constraints and other complications serve to reduce life expectancy (Vandenbrouche et al., 1984).

SUMMARY AND CONCLUSIONS

This chapter has examined the concept of rheumatoid arthritis. It has argued that the classification of diseases is limited by linguistic and cultural determinants which affect the concept of rheumatoid arthritis. The definitional process can at best be described as quasi-scientific. The classificatory framework does not give evidence of a logical or ordered structure of diseases. The role of the patient has been largely ignored in this process and the psychological concomitants of the disease have not been included.

The diagnostic criteria appear to be an arbitrary list of items that lack internal structure or coherence. The

imprecision and variety suggest that rheumatoid arthritis may indeed not be one condition but could comprise a number of diseases.

This is not a medical piece of research and no position is adopted in the debate regarding the reliability or validity of the diagnostic criteria of rheumatoid arthritis. For the purposes of the research the actual existence of a disease is not important. It is sufficient that patients are told they suffer from rheumatoid arthritis because the research is concerned with how they respond to that information.

The evidence produced has been judged critically but this has been done, not to unfairly destroy the existing criteria but to show that there is an inevitable lack of precision which reduces the possibility of scientific procedures in the classic sense. This doubt is found in medical discussions and the medical literature, over both the diagnosis of the disease and the methods of treating it. It will be argued in Chapter 5 that the variability in approach can affect the patient's treatment. A patient who passes between his GP and Consultant Rheumatologist can be subjected to considerable confusion and uncertainty over what he is supposed to do, how he should help himself and what medical regimen he should follow. This confusion and uncertainty is inevitably bound up with the diverse elements of the definition of rheumatoid arthritis. This confusion and uncertainty ultimately is a source of stress and anxiety for patients.

The investigation of the diagnostic criteria also

establishes that symptoms such as pain and stiffness have psychological concomitants which have been ignored. For many patients the psychological concomitants of the disease are important. Without a consideration of this dimension the total effect of having the disease, both for patient and physician, cannot be accurately assessed. The investigation of the psychological concomitants of rheumatoid arthritis is considered in Chapter 2.

THE PSYCHOLOGICAL CONCOMITANTS OF RHEUMATOID ARTHRITIS

INTRODUCTION

Chapter 1 argued that the definition of rheumatoid arthritis caused uncertainty and confusion for patients and physicians because it failed to define a clear concept. It was evident that the disease was not an easily understood entity and it failed to fit logically within a nosological classificatory framework. It was shown that the diagnostic criteria depended solely upon physical symptoms, serological tests and X-rays. The diagnostic criteria did not include the psychological concomitants of the disease. It is argued in this chapter that the failure to include the psychological aspects makes it difficult to understand the impact that the disease has upon either the patient or the physician. This chapter is divided into three separate Sections.

Section 1 examines the development of different psychological approaches to medicine over the course of the Twentieth Century. It identifies three separate approaches, behavioural psychology, medical psychology and health psychology. It argues that an approach based upon health psychology is the most appropriate because it provides the most comprehensive framework against which the disease can be discussed. The section also establishes that there are psychological concomitants connected with health and it provides specific evidence that the existence of psychological concomitants for rheumatoid arthritis have

been known since at least 1909.

Section 2 is specifically limited to the diagnostic criteria discussed in Chapter 1. Chapter 1 noted that the diagnostic criteria could be divided under three headings of physical symptoms, serological tests and X-rays. It is argued that if the psychological concomitants had been considered to be of importance then it would be possible to identify studies in the literature that illuminated the connection between the diagnostic criteria and the psychological concomitants. Section 2 carries out that examination and concludes that there is little evidence that a connection has been made between the diagnostic criteria and the psychological concomitants.

Section 3 traces the development in the psychological literature of the investigations that have been conducted into rheumatoid arthritis. It notes that an extensive literature exists that illuminates and documents the psychological concomitants of the disease. The literature is discussed under a variety of headings that are generally found in psychological literatures. It is noted that these headings do not reflect the divisions of the diagnostic criteria.

The chapter ends with a summary and conclusions where it is argued that on the basis of the evidence submitted there is a need for a therapeutic intervention to help patients cope with the psychological concomitants of rheumatoid arthritis.

Section 1

HISTORY OF PSYCHOLOGY

It is not the intention of this chapter to give a

historical account of the development of psychology, that has been adequately covered elsewhere (Kimble and Schlesinger, 1985). From Chapter 1 it was evident that by the nineteenth century, academic investigations were essentially analytical, reductionist and objective in the sense that the only acceptable valid knowledge was scientific fact, which was objectively verifiable.

Psychology developed largely against this scientific background and attempts were made to justify it as an objective natural science. It was deemed necessary to adopt the methods and principles of physics, which in the Cartesian and Newtonian tradition meant satisfying the standards of scientific rigour and objectivity. This approach meant that psychology did not consider senses, feelings and subjective consciousness to be part of its discipline. In so doing psychology alienated man from his experiences, himself and his existence (Laing, 1983). This alienation was supported by the evolutionary theory of Darwin which emphasised man's subordinate position in a scientific world.

'By demonstrating that man was genetically related to the lower orders and that he retained active residues of his own primitive ancestry, Darwin made it easy to believe that the tendency to regress was not an accidental misfortune, but was written into the very constitution of man'. (Miller, 1982, p. 323)

Except for the work of Jung and Freud and a few others, psychology became the scientific analysis of behaviour.

'Psychology is trying to imitate the natural sciences and laboratory methods of weighing and counting, dealt with everything except the soul. It tried to understand those aspects of man which can be examined in the laboratory, and claimed that conscience, value judgements, and knowledge of good and evil are metaphysical concepts, outside the problems of psychology; it was often more concerned with insignificant problems which fitted the alleged scientific method than with devising new methods to study the significant problems of man. Psychology thus became a science lacking its main subject matter, the soul.'

(Fromm, 1951, pp. 13-14).

This position was to change as the twentieth century developed. Although science was to dominate early psychology other approaches became discernible particularly from the work of Jung and Freud. It was not long before it was maintained by psychologists that psychology had an important role to play in medicine.

DEVELOPMENT OF DIFFERENT APPROACHES TO PSYCHOLOGY AND MEDICINE

A case was made for a greater contribution by psychologists to medicine as long ago as 1911 (Gentry and Matarazzo, 1981). During the last two decades medical psychology has become established as an academic discipline (Hetherington, et al., 1964; Coleman, 1977; Wright et al., 1977; Stone et al., 1980; Genest and Genest, 1986). As an academic discipline medical psychology has been divided into

specialist topics such as memory, intelligence, anxiety, depression, affect, neurosis and psychosis. This scientific method of reducing subjects into smaller topics has been noted in Chapter 1. However this traditional topic focused approach has changed during the last decade. The academic study of psychology has resulted in more interest in medicine and a number of more unified approaches are now apparent.

The three approaches that have been used most frequently are behavioural medicine, medical psychology and health psychology.

Behavioural medicine is concerned with the knowledge and techniques relevant to the understanding of physical health and illness and its application to prevention, diagnosis, treatment and rehabilitation (Gentry, 1982). Behavioural medicine adopts the same approach as experimental psychology. As such it is open to the criticism that it is a -

'science of totally artificial behaviours in

essentially unreal settings.' (Westland, 1978, p. 19)

Its artificiality lies in it being almost totally structured by an experimenter who selects equipment, defines the variables under study, determines the intervention, chooses the sample and directs procedures. The whole situation is under the control of the experimenter who created it and it is in no way independent of him (Giorgi, 1970).

Medical psychology has been used to define a wider subject area and would include psychological aspects of medicine as well

(Rachman, 1980). Medical concepts are the main means of definition and organisation in medical psychology. Chapters in textbooks are frequently organised using disease or other medical categories, rather than psychological ones (Williams and Gentry, 1977; Propkop and Bradley, 1981). It does not provide a satisfactory account of how everyday life is actually made to work by the human beings who conduct it (Harre, et al., 1985). That is because meanings for people are generated through action and the actions do not take place in a vacuum but in a social context. Psychological activities occur in a moral order. This order guarantees people rights. It is because of this moral or social order that psychology cannot be assumed to follow the same kind of experimentation as the physical sciences. The physical world and therefore the physical sciences have nothing like a moral or social order in which psychology is grounded, and clearly the physical sciences are devoid of moral or social concepts (Shotter, 1975).

The approach of medical psychology is still rooted in the scientific model which has been increasingly found inadequate for describing a subject as complicated as a person's health (Style and Style, 1982). The concepts embodied within medical psychology are under pressure to include other aspects of health. The new area comes under the title of health psychology.

Health psychology has been recognised as providing a more comprehensive approach and the concept has gained support. The American Psychological Association formed a Health Division and the British Psychological Society inaugurated a

Health Psychology Section in 1986. The definition of health psychology adopted by the health psychology section is that of the American Psychological Association.

'Health psychology is the aggregate of the specific educational, scientific and professional contributions of the discipline of psychology to the promotion and maintenance of health, the prevention and treatment of illness, the identification of etiologic and diagnostic correlates of health, illness and related dysfunction, and the analysis and improvement of the health care system and health policy.' (Marteau and Johnston, 1987, p.82)

This definition allows two omissions from the medical psychology area to be focused upon. Firstly, the patients' concerns beyond the medical care setting which were largely ignored can be included. Secondly, the stress involved with medical care for staff which have been largely ignored can also be included (Marteau and Johnston, 1987). This second aspect allows the current medical perspective which promotes the role of the medical profession as observer rather than observed, introducing a fundamental attributional bias, attributing variance to the patient and ignoring the medical professional (Bradley, 1985).

It has been shown that the beliefs and attitudes of medical professionals influence the health outcomes of their patients (Novack, 1979). The outcomes are not just psychological aspects of care but physical as well, as has been found in the case of diabetic patients (Weinberger et

al., 1984). Diabetes, like rheumatoid arthritis, is a chronic condition. When psychologists have been asked to help with patients they tend to see themselves, or are cast in the same healing role as doctors. Likewise their beliefs and attitudes influence patients and health outcomes. Investigations carried out by psychologists as observers are susceptible to the same bias as medical professionals. An attempt to overcome this problem in the research design will be discussed in Chapter 4.

The definition of health psychology is adopted in this chapter so that the psychological concomitants of rheumatoid arthritis can be investigated. It is hoped that this approach will bring rheumatoid arthritis and psychology into closer correspondence with each other and will illuminate the areas where closer links might provide new therapeutic approaches for patients. In this chapter the symptoms of the disease are examined and each of the diagnostic criteria are investigated to determine whether or not they have concomitant psychological aspects.

PSYCHOLOGICAL CONCOMITANTS OF RHEUMATOID ARTHRITIS

It has been recognised since the beginning of the Twentieth Century that the disease of rheumatoid arthritis has psychological components. Writing in 1909 Jones maintained:

'That mental shocks, continuous anxiety and worry may determine the onset, or provoke an exacerbation of rheumatoid arthritis is, I

think, beyond question.' (Jones, 1909, p. 3)

This argument has been developed as the century has progressed. It received further support in the 1920's and 1930's (Nissan, 1934; Ray, 1934; Rivers, 1934). The development led to a number of seminal papers that investigated the psychological concomitants of the disease (King, 1955; Moos, 1964; Ward, 1971; Vignos et al, 1972; Crown et al, 1975; Wiener, 1975; Spergal et al, 1978; Earle et al, 1979; Gardiner, 1980; Shamoian, 1980; Achterberg-Lawlis, 1982; Baum, 1982; Rogers et al, 1982; Genest, 1983 and Anderson, 1985).

These investigations pursued the various psychological concomitants but did not relate them to the medical diagnostic criteria of the disease. This would appear to be shortsighted and a consequence of following a scientific, deterministic and reductionist methodology which makes a holistic investigation of both types of phenomena less likely. The argument leads to the illogical situation where an attempt is made to identify psychological factors in isolation from the diagnostic criteria.

The papers quoted above made little attempt to link the psychological concomitants with the diagnostic criteria, rather they pursue an interest in academic psychology which ignores the physical consequences of the disease. This line of investigation permits psychological comparisons to be made with patients suffering from other diseases but discourages comparisons across the boundary of psychology into other disciplines. People's reactions to their own health are extremely complex and it is unlikely

that any meaningful conclusions will be reached when the area under investigation is narrowly restricted to academic topics.

When a patient's symptoms are acute, severe, unusual or disabling, patients will almost invariably seek medical assistance. However, when symptoms are mild, chronic or common, a host of non-medical factors influence the decision to consult a physician (Apple, 1960; Stoeckle, 1963). Most people who experience ill-health choose not to visit a physician (Williamson, 1964; Kosa, 1967). However, during a 14 day recall period about 95% of the general population report symptoms which they attribute to illness or injury, only 76% take any specific action, and only 32% consult a physician (Wadsworth, 1971). Perhaps more interesting is the finding that in terms of the number and type of symptoms, those who attend their physicians are no more sick than those who do not (Wadsworth, 1971).

Because many ill people do not attend their physician, factors apart from disease and symptoms must be important in explaining why other equally ill people do not attend. 68% to 92% of the patients who visit their physician have no serious medical disease (Blackett, 1954; Garfield, 1976; Van der Gagg and Van der Ven, 1978). Only 41% of the identified problems of patients are clear somatic diagnoses (Lamberts, 1979), and the commonest single diagnosis made in general practice is "no disease" (that is no detectable structural or functional abnormality) (Brown, 1971). Because modern medicine tends to focus on disease rather than the patient's perception of, and response to the symptoms,

patients are often labelled "medical care abusers" (Ries, 1981). It has been estimated that the "worried well" are responsible for 50% of the cost of adult ambulatory general health care (Barsky and Klerman, 1983).

It is apposite to consider the reasons why symptoms diagnosed by patients become reasons for consulting doctors. It would appear that people assess their symptoms by four different criteria in deciding whether they should seek medical advice. First there is the symptom's intrinsic nastiness, pain is intrinsically nasty, as is nausea. Secondly there is alarm, where a person passes blood in their urine or discovers a lump in their abdomen. Thirdly, symptoms that cause reduced efficiency or restrict freedom of action. Lastly there is the symptom that causes embarrassment or shame, such as facial rash or squint. All of these have psychological concomitants. These are real symptoms for the patient and what determines a person to seek medical advice, although they may not be medical diagnostic criteria. So falling ill is not something that happens to people, but it is a conscious choice they make as a result of a symptom (Miller, 1982).

This chapter seeks to broaden the traditional topic focused psychological approach by taking into account the individual's conscious control of his health. The diagnostic criteria discussed in Chapter 1 will be investigated to determine what the psychological concomitants of those items are. The investigation of the diagnostic criteria will be made first. This investigation will show that there are few studies in the literature. Then other psychological topics will be considered and it will be

seen that the traditional topic focused psychological literature does contain a considerable number of studies.

Section 2

PSYCHOLOGICAL CONCOMITANTS ASSOCIATED WITH DIAGNOSTIC CRITERIA

Patients identified stiffness and pain as the most frequent symptoms when asked about arthritis (Price et al, 1983; Room, 1984). The subjectivity of what a patient will label as stiffness for example, or the examiner's basis for determining whether there is pain on motion of a joint, are issues that are not resolved in the literature and are infrequently recognised (McCarty, 1972; Genest, 1983). Patients do agree that it was a very painful condition and accepted that it was a disease and not just another name for normal aches and pains associated with joints (Badley and Wood, 1979).

MORNING STIFFNESS

Although morning stiffness is one of the main diagnostic criterion it does not receive a great deal of attention in the psychological literature. Although mentioned in the literature, it is not exhaustively discussed. This may be because it is a difficult concept to explore and why it is not further discussed (Genest, 1983). Morning stiffness is a subjective symptom and depends upon self report, unless patients are undergoing a period of hospitalisation when it can be observed. It is interesting that of the first six criteria, morning stiffness is the only one that does not require a physician's observation. There

is no logical reason why this should be so except for practical purposes. It does however establish the principle that a patient's self report is acceptable as diagnostic evidence.

The reliability of morning stiffness as a diagnostic criterion is not supported by empirical data.

'The fickle nature of the symptom was shown by answers given by 467 subjects between the ages of 55 and 64 who were asked whether they experience stiffness in the mornings. 132 answered positively at home, 118 when they were reviewed in hospital, but only 74 on both occasions.' (Wright, 1983, p. 224)

The diagnostic criterion of morning stiffness is a focal point in the diagnostic procedure, although the subject is not one that has been extensively researched.

'The subjectivity of what a patient will label as 'stiffness' is an issue that is not resolved in the literature- that are, in fact, infrequently recognised.' (Genest, 1983, p. 395)

The motivational drive of a patient is clearly an important determinant. The sooner the patient can overcome stiffness he can begin his day. Oddly, motivation does not appear prominent in the literature and there appears to be a dearth of studies. The only study that investigated motivation did so in the context of rehabilitation (Vignos et al, 1972). They found that there was no positive correlation between improvement in disease activity and a good motivation index. Improvement in disease activity

does not appear to alter motivation to rehabilitation. Better health status and potentially better psychological reaction to disease does not appear to be important in altering the basic motivation of the patient toward rehabilitation.

PAIN

Unlike morning stiffness there is no scarcity of papers investigating pain and rheumatoid arthritis. The ARA criteria links pain with tenderness but does not attempt to distinguish between the two. The symptom does have to be observed by a physician, although without visible signs such as swelling (dealt with next) or pain witnessed during physical examination, the physician would appear to have to rely upon the patient's verbal report.

It was noticeable that there was no mention of a time period. Rheumatoid arthritis is a chronic disease and the pain associated with it is regarded as being different from acute diseases. Chronic pain has been formally defined as a pain which has persisted, despite the use of medical treatments, for at least four to six months (Roberts and Bush, 1981; Pearce, 1983).

Patients with rheumatoid arthritis experience pain from a multiplicity of sources. It may include local pain in joints due to inflammation or chronic changes in articular tissues. As rheumatoid arthritis is a systemic disease other organs or parts of the body might be involved. Pain can also be brought on from the side-effects of medication or from emotional changes in the patient (Hart, 1974).

The ARA criteria puts the responsibility upon the

physician to confirm the pain. Subjective definitions of pain are not adequate although they are acknowledged as valid by some medical professionals:

'Pain is whatever the experiencing person says it is and exists whenever he says it does.' (McCaffery, 1972, p. 8)

The complexity of diagnosing pain is evident from a continuum that runs from the subjective self report method suggested above to the objective independent observer method where pain is diagnosed by an observer watching a patient undergo certain physical movements (McDaniel et al., 1986).

The pain that is important to the physician is pain that can be used as diagnostic criterion and this normally emanates from a somatic source. The physician has to rely upon the self report of the patient and this is of doubtful validity at times. Patients frequently describe pain as stabbing, but very few people have been stabbed. Different people could be imagining quite different sensations.

'Presumably the patient abstracted from his idea of stabbing an image of violent penetration which he uses in a metaphorical way to refer to his own pain'. (Miller, 1982, p.38)

The somatic description of pain is becoming increasingly questioned and most medical professionals would accept that there was a psychological component in pain.

In common with other painful disease, there are examples of patients with demonstratable organic pain but

who do not complain of pain (Crown et al, 1975). Conversely, there are patients with severe joint pain who do not show positive immunological results (Mason, 1975). This evidence suggests that the relationship between rheumatoid arthritis and pain is involved and complex and that organic and psychological causes must be jointly (no pun intended) taken into account.

The earliest theory of a physiological account of pain dates to Descartes who argued that pain sensations were elicited by an external stimulus. The stimulus resulted in the detection and identification of pain. Messages were sent from pain receptors through neural pathways to the pain centre of the brain. The concept of the direct, specific transmission pathway has been developed and provides the underlying concept for later theories (Melzack and Wall, 1984).

The concept that there was a simple pathway from subcutaneous pain receptors to the pain centre of the brain was adapted and developed into the pattern and sensory theories of pain. Although these theories go some way to refining the experience of pain they are still subject to the same criticism, namely that pain is seen as a physical experience which was not modulated by psychological factors (Holroyd and Andrasik, 1982).

Irrespective of the theories it has long been acknowledged that emotions play a part in the experience of pain. Pain associated with 'passions of the soul' was located in the heart (Merskey, 1980). More recently clinical investigations have shown that the emotional response to pain is very complex and has mediating factors (Beecher,

1959).

An attempt to integrate the emotional or psychological aspects of pain with the physiological was made in the gate control theory of pain (Melzack and Wall, 1984). This theory postulated that an optimum set of psychological and physiological factors must operate before pain is experienced. The physiological factors are signals from a injured site which go to the dorsal horn of the spinal cord. The gate in the dorsal horn is also affected by psychological signals from the brain which can serve to influence whether the gate should be opened or closed. Whilst there is no neurological evidence for the existence of such a gate (Nathan, 1976), the theory does try to incorporate the two sets of stimuli.

Despite this development, the dichotomy between physical and psychological causes of pain still tends to be prevalent. Evidence of the dichotomy can be found in the current concerns of physicians and psychologists. Physicians still tend to perpetuate the belief that pain in rheumatoid arthritis arises from organic sources (Grennan and Jayson, 1984). Psychologists tend to investigate the sensory, cognitive and behavioural aspects of pain (Skevington, 1986). However many of these psychological investigations proceed from the premise that rheumatoid arthritis pain has a physical source and ignore that the source may be psychological (Bradley, 1984; Bradley, 1985; McDaniel et al., 1986).

The trend to ignore the psychological aspects of rheumatoid arthritic pain appears to be influenced by other

factors. Patients have a strong somatic focus to their illness (Skevington, 1983) which has been substantiated by psychological measurement (Pilowsky and Spence, 1975).

Achterberg-Lawlis argues:

'The traditional mental health models for therapy simply appear unacceptable for people who are brought together with a common diagnosis of arthritis.' (Achterberg-Lawlis, 1982, p. 988)

The reaction of patients is partly accounted for by the pervasive influence of psychiatry. This influence is inextricably bound up with terminology where psychiatric labels carry the connotation of mental illness and patients cannot see the relevance of it to their complaint.

Psychiatric influences have tended to give way to behavioural theories of pain and some significant results have been achieved with them although they have not always been reported with complete biographical patient detail's (Fordyce, 1976).

Many of the questionnaires used in the measurement of pain for rheumatoid arthritis have been standardised using psychiatric populations. Consequently many of the questions may be inappropriate to patients suffering from the disease. In a similar way the use of depression scales for pain patients has been recently criticised (Romano and Turner, 1985) and the use of the MMPI (Gardiner, 1980). Not only do the tests seem inappropriate, but in addition there is evidence that the concepts themselves are poor predictors of general health and arthritic status (Skevington, 1986).

It is clear that pain can have a somatic or

psychological source. Whether differences are reflected in either the diagnosis or pathogenesis of the disease are not clear. There does not seem to be an effective and concise way of measuring pain objectively and inevitably the physician has to rely upon self report. A recent research study has shown that trained research assistants can accurately and reliably assess patient's pain from observations of them which could corroborate patients' self report (McDaniel et al., 1986). Perhaps this will prove to be a profitable area of research.

Research into pain syndromes has advanced across a wide front. Various attempts have been made to establish pain syndromes for different diseases by using a list of pain describing words (Nehemkis and Charter, 1984). Attempts have been made to distinguish different descriptions of pain between patients who suffered from rheumatoid arthritis and osteoarthritis. The evidence from these studies is contradictory.

In another area of research one study found it was possible to diagnose the difference between rheumatoid arthritis and osteoarthritis on the evidence of words describing pain (Wagstaff et al., 1985). This has been contradicted by investigations which, with regard to the complexity of the pain experience, could find no distinguishable differences between groups of rheumatoid arthritis or osteoarthritis patients (Charter et al., 1985).

From a study of the literature it appears that the physician is only interested in somatic pain and it can equally be maintained the psychologist is only interested in

psychological pain. The continued existence of these differences does not help an accurate and comprehensive description of a patient's pain to be determined. There does seem to be some evidence that psychologists are finding the most appropriate approach to pain therapy is by way of cognitive-behavioural therapy. The approach actively involves the patient and the collaboration is an improvement on the medical approach which tends to assign the patient to a more passive role (Bradley et al., 1984; Bradley et al., 1985). This account of the psychological issues involved with pain is unsatisfactory and other aspects will be returned to later in the chapter.

SWELLING

The American Rheumatism Association devotes three items to swelling in its diagnostic criteria. There is considerable variation between the items listed in Chapter 1. The variation ranges from one joint to many joints in symmetrical joint swelling. The logic of having three criteria is not apparent. One item mentioning 'one or more joints' would have covered the three criteria. Whether a more accurate diagnosis can be made with three items seems doubtful and whether it facilitates the application of constant criteria seems equally doubtful. Item 6 can purposefully be considered with swelling. It refers to subcutaneous nodules which are growths under the skin. They are most frequently found near the elbows, or on the hands or feet.

There are no references to swelling or subcutaneous nodules in the psychological literature

connected with rheumatoid arthritis. This seems an omission as both can be disfiguring and affect self image. Self image is recognised in psychology as an integral part of the self concept and therefore a main topic in the literature (Kelly, 1955; Goffman, 1959; Rogers, 1961; Erikson, 1963; Coopersmith, 1967; Maslow, 1970; Wylie, 1979; Burns, 1982; Argyle, 1983;). Self image comprises a cerebral recognition of the position, shape and boundary of the body, and of the physical, mental and emotional actions made with it in its environment (Webster and Sobieszek, 1974). Subcutaneous nodules and swelling affects both the shape and boundary of the body and what actions it can make. The reason for the omission may be that the medical psychological literature is grounded in behaviourism, whereas the self image is more closely aligned with humanistic psychology as Chapter 3 will show.

X-RAYS

X-rays form a standardised part of the rheumatoid arthritis diagnosis. The criteria on which they are based is universally accepted (Larsen, 1981). The X-rays show the space between the joints and any loss is an indication of the disease process. X-rays can also show joint destruction and dislocation. Decalcification can also be present. This is the loss of calcium salts associated with osteoporosis and is shown by loss of bone density.

X-rays are part of the technology of medicine. They are not a therapeutic intervention and are used only for purposes such as diagnosis or monitoring treatment. As

such they do not have psychological concomitants. The process of being X-rayed may cause psychological stress but typically waiting for the result induces greater stress as noted below. The evidence that x-rays reveal is normally concerned with changes in self image and has been dealt with above.

RHEUMATOID FACTOR

Item 8 refers to the rheumatoid factor. This is a test from blood to investigate whether the disease is seronegative or seropositive. The test establishes whether a person is making antibodies which would be an immunological reaction to the disease and, if so, is termed seropositive. The results of the test show that seropositive arthritis may be clinically indistinguishable from seronegative rheumatoid arthritis although the prognosis for the latter is generally better.

Unfortunately for the individual patient the test may not be very helpful for diagnostic purposes as only approximately 70% of people with rheumatoid arthritis can be detected by the test and this tends to be usual in cases of early or mild rheumatoid arthritis where early diagnosis can be most useful in providing therapy. In addition the test is not specific to rheumatoid arthritis. It can be positive for other diseases and also in a proportion of the general population who are without disease.

These tests can cause insecurity for patients particularly when a diagnosis is first being made. They are aware that the blood has been drawn for tests and they are anxious over the results. This can be a recurring source of

stress each time a hospital visit is made. Medical professionals are aware of this anxiety (Scott, 1980). The anxiety arises from the outcome and not the process (Weinman and Johnston, 1986). The highest published mean anxiety score recorded on the state scale of the Spielberger State-Trait Anxiety Inventory was for patients awaiting the results of tests (Robinson et al., 1984).

POOR MUCIN PRECIPITATE FROM SYNOVIAL FLUID

For item 9 the synovial fluid is examined. The synovial fluid is responsible for the lubrication of the joint. It should be clear and not viscous. Extensive studies have been carried out on the concentration of mucin in the synovial fluid (Ropes and Bauer, 1953). Synovial fluid can be aspirated from the joint and acetic acid is added to assess the type of mucin that is precipitated. The specificity of the test is in doubt.

'It is generally known that the mucin test gives only rough clues and does not have significant advantages over a visual assessment of the relative viscosity of synovial fluid as the aspirated fluid is expressed from the syringe. The mucin test and viscosity are not a reliable basis for the classification of the pathogenesis of effusions.' (Vernon-Roberts, 1986, p. 261)

This test is not widely used because as indicated above it is not a very definite diagnostic test. In addition there are practical difficulties. It is a difficult

procedure to aspirate synovial fluid and the patient has to be anaesthetised.

The literature does not mention any psychological concomitants, although the psychological ^{concomitants} already explored are obviously involved.

SYNOVIAL HISTOLOGY OF RHEUMATOID ARTHRITIS

There are no references in the literature to psychological concomitants.

NODULE HISTOLOGY OF RHEUMATOID ARTHRITIS

There are no references in the literature to psychological concomitants.

CONCLUSION OF THE PSYCHOLOGICAL CONCOMITANTS

The various psychological aspects associated with the diagnostic criteria of rheumatoid arthritis have been examined. It is obvious from the investigation that psychology and rheumatoid arthritis have not been closely linked. The diagnostic criteria are physical, serological or x-rays and appear to ignore large areas where important psychological factors should be taken into account if the disease is to be understood properly.

Section 3

PSYCHOLOGICAL CONCOMITANTS IN THE PSYCHOLOGICAL LITERATURE

It has not been possible to incorporate much of the psychological literature under the diagnostic criteria. This literature is extensive and will now be examined. The first concept to be explored is that of the arthritic

personality.

THE ARTHRITIC PERSONALITY

Although they were eventually to be proved incorrect there are many reports in the medical literature of a special cause and effect relationship between rheumatoid arthritis and a particular type of personality. These reports are usually based upon subjective findings which include self-reports of patients as being self-restricted, detached, emotionally calm and compulsive (Halliday, 1941). Other studies maintain that patients have a repressed rebellious resentment against parental dominance and that their personality differs from both normal and neurotic groups (Johnson et al., 1947; Polley et al., 1970; Ward, 1971). Hostility has been mentioned by a number of studies some of which suggest that the hostility is repressed and patients enact a rage against their own body (Ludwig, 1952; Mueller and Lefkovits, 1956; Cormier et al., 1957; Cobb, 1959; Geist, 1966; Geist, 1969; Robinson, 1969). Other studies argue that it is not hostility but aggression which tends to be a characteristic of the patients (Udelman and Udelman, 1978; Potts, 1984). Other investigations mention suppressed anger (Cleveland and Fisher, 1960; Rogers et al., 1982), but these investigations are contradicted by other studies which concluded that patients were easily aroused to anger (Booth, 1937; Cormier et al., 1957).

Several reports written during the 1950's and 1960's suggested that patients shared a specific premorbid personality which was rigid, self-punitive and passive. It was also characterised by difficulty in dealing with hostility and aggression (Potts, 1984). Much of the evidence came from a series of papers by Cobb and King that investigated psychosocial factors (King, 1955; King and Cobb, 1958; Cobb, 1959; King and Cobb, 1959; Cobb et al., 1959).

However, much of this evidence has not withstood the test of investigation. Many of the studies were uncontrolled and methodological seriously flawed (Scotch and Geiger, 1962; Weiner, 1977; Genest, 1983). Other studies have replicated some of this early work and find there is little evidence to suggest that rheumatoid arthritic patients differ on personality tests from non-rheumatic patients (Crown et al., 1975). There is evidence to show that the personality characteristics believed to be a cause of rheumatoid arthritis are not specific to the disease but are common to chronic diseases in general (Stein, 1959; Schochet et al., 1969; Wolff, 1971; Kiviniemi, 1977; Spergel et al., 1978).

There are obviously many contradictions in these findings despite the number of studies undertaken. It would appear that even from an early date methodological criticisms were common. These methodological criticisms include: significant differences across studies in theoretical orientation and assessment procedures; inattention to patient's general medical information and sociodemographic characteristics; heterogeneity within the

rheumatoid arthritic population; excessive attention to negative personality characteristics; lack of appropriate control groups (this factor will be more fully discussed in Chapter 4); and the retrospective nature of the research (Moos, 1964). The retrospective nature of the research will always be an important factor until general population samples are examined (Anderson et al., 1985).

The medical characteristics of patients suffering from rheumatoid arthritis means that patients respond to psychological questionnaires according to: rate of disease progression; medication; presence of serum antibodies; disease stage; and psychosocial factors (Vollhardt et al., 1982). The criticism that researchers have failed to record general medical information and sociodemographic characteristics may be reflected in the inconsistent findings. It may be that this failure is due to different subgroups of rheumatoid arthritis patients. These different subgroups may be a consequence of that fact that a number of different diseases come under the single heading of rheumatoid arthritis as was discussed in Chapter 1.

The evidence for the existence of an arthritic personality invariably came from psychological questionnaires. These questionnaires were typically drawn up by one researcher for individual use and rarely used again. It has been found that over 50% of studies of the arthritic personality have used psychological tests that were devised by the investigator and were not used by other researchers (Baum, 1982). Many have questionable psychometric properties. The subtle personality changes associated with

onset or reaction to chronic disease might not be adequately assessed by the questionnaires. Many of the investigations and particularly the earlier ones were based upon anecdotal cases studies or loosely structure interviews and their findings are open to bias (Achterberger-Lawlis, 1982).

In conclusion there is little or no support for the existence of an arthritic personality that antecedes the disease and in some way leads to its onset. Negative personality characteristics noted among rheumatoid arthritic patients are more feasibly explained as reactions to this chronic condition than as causal factors. Towards the end of the 1970's the concept of the arthritic personality had been fully explored and it was concluded that it was a psychodiagnostic myth (Spergel et al., 1978). This finding has been upheld by later reviews in the psychological literature (Earle et al., 1979; Gardiner, 1980; Shamoian, 1980; Achterberger-Lawlis, 1982; Baum, 1982; Rogers et al., 1982; Genest, 1983; Anderson et al., 1985; Skevington et al., 1987).

PSYCHOSOCIAL FACTORS

Rheumatoid arthritis is a chronic disabling disease which affects an individual's ability to cope with the normal activities of daily living. The patient's dependence upon family members places increased pressure upon the unit. Most investigators agree that social factors are important in the total management of rheumatoid arthritis (Vignos et al., 1972; Spergel et al., 1978; Meenan et al., 1981; Baum, 1982; Anderson et al., 1985). Patients are aware that they lose their independence and become an

additional responsibility for the family (Masters et al., 1983). In one study of housewives with rheumatoid arthritis the majority feared losing their independence. They also felt a burden upon the family and this lead to feelings of guilt (Wright and Owen, 1976).

Long term relationships are subjected to continued pressure. Studies of marital stress among rheumatoid arthritis patients, however, have produced conflicting results. Several studies have reported an increased incidence of divorce compared with normal controls (King and Cobb, 1958; Cobb et al., 1959). Other investigations have reported that there is no definite relationship between rheumatoid arthritis and divorce (Empire Rheumatism Council, 1950; Hellgren, 1969). In one study using a control group of patients with rheumatic disease other than rheumatoid arthritis it was found that there was a greater incidence of divorce and a lower rate of remarriage in female patients with rheumatoid arthritis (Medsger and Robinson, 1972). Although most divorces preceded the onset of the disease by several years, the lower rate of remarriage was associated with the course of the disease.

The long term effectiveness of available therapy is fairly limited in rheumatoid arthritis so the patients will continue to encounter major social difficulties (Katz et al., 1968; Lee et al., 1974). When psychosocial adjustment was measured using five attitude scales, rheumatoid arthritis patients expressed lower self-esteem, lower work satisfaction and a greater sense of meaninglessness with their lives than did healthy controls (Earle et al.,

SEXUAL PROBLEMS

It is found that reviews of the rheumatoid arthritis literature mention that patient s' sexual problems are frequently neglected (Smith, 1979; Baum, 1982; Anderson et al., 1985). It was not until the last decade the rheumatology textbooks mentioned the sexual problems encountered by patients at all. This may reflect a lack of adequate medical training (Ehrlich, 1973; Katz, 1977).

Some of the earlier studies (Cobb et al., 1959, 1965, 1966, 1968) developed the hypothesis that patients with rheumatoid arthritis feared emotional experiences and emotional dependence and they developed an unconscious resistance to emotion. This acted as a mental defence mechanism that led to the denial of sexual need (Booth, 1937; Booth, 1939). Another view was patients were not well adapted sexually in their marriages and they tended to display considerable conflict (Bourestam and Howard, 1965). More recent studies appear to have viewed the physical limitations imposed by the disease in a more sympathetic way.

Psychologists have become aware that the disease causes pain, fatigue and reduces mobility and these factors have an effect upon sexual functioning. Chronic pain and illness can adversely affect sexual desire and the capacity for arousal and release (Wise, 1983). Studies have established in samples of outpatients and total hip replacements that there has been a negative change in sexual activity since disease onset (Elst et al., 1984; Baldursson

and Brattstrom, 1979). Over 50% of women reported decreased frequency of intercourse, decreased libido and occasional orgasmic dysfunction since disease onset (Yoshino and Uchida, 1981).

In a retrospective study of adults who had rheumatoid arthritis as adolescents, nearly all the patients said that they would have benefited from sexual counselling in adolescence. A delay in reaching sexual maturation can be caused by the disease and as a result patients can have more sexual problems than normal (Herstein et al., 1977). Adults and adolescents can be affected by medical, psychological, physical and pharmacological factors that cause sexual dysfunction.

FAMILY RELATIONSHIPS

Two studies investigated family factors that affected outcomes. Both examined the use of hand splints and compliance with the instructions for their use. Family expectation appeared to be the strongest factor related to the use of splints. Lower social class families complied more readily than those in the middle or upper social classes. Females complied better than males and older patients better than younger patients (Oakes et al., 1970; Moon et al., 1976).

The actual stability of the family unit appears to be another factor. A higher proportion of rheumatoid arthritic patients had lost either one or both parents before the age of 16 (Rimon, 1969). The stability of the family unit could also be affected by modes of parental

discipline. Punitive parental behaviour was positively correlated with the subsequent development of the disease. The behaviour of the parents caused resentment in patients over a long period of time. Some children may have suppressed the anger which could have been the cause of the disease occurring in adult life. These features appear to be consistent in a significant number of women who gave descriptions of arbitrary authority on the part of their mothers, but not in the case of men (Cobb et al., 1959; Cobb et al., 1965; Cobb and Kasl, 1966; Cobb and Kasl, 1968).

These early studies have been supported by a more recent study that found a significantly greater number of rheumatoid arthritic patients had experienced stressful life events than a control population. Only 14% of patients failed to report either a negative relationship with their mother or a stressful life event before the onset of the disease. Negative relationships with mothers were particularly prevalent among female patients (Baker, 1982).

In a matched controlled study it was found that in the twelve months preceding disease onset a significantly higher number of stressful events were reported by patients over controls. Patients were more likely to have; moved to a new school, experienced the birth of a sibling, seen their parents separate or divorce, been hospitalised for symptoms other than rheumatoid arthritis or suffered the death of a parent (Heisel, 1972). Where there is severe disruption in the family unit family therapy is recommended as a means of reducing stress (Zeitlin, 1977).

ECONOMIC FACTORS

The economic consequences of the disease can be considerable because it is a lifelong complaint which causes progressive physical impairment (Weiner, 1976). Since its prevalence rate increases with age the disease becomes more common as the proportion of older people in the population grows (Masi and Medsger, 1979).

The economic consequences of the disease can mean that as many as 60% of patients have to terminate work and in 82% of those cases termination was attributed by the patients to the effects of the disease. Two factors mitigated against disability and they were self-employment and substantial autonomy at work. This would appear to correlate with the independence factor seen in Psychosocial Factors above. Income dropped significantly and 69% of patients earned only 50% of what they could have expected to earn before disease onset (Meenan et al., 1981). The study did not include a control group and neither did the two previous studies which arrived at similar findings (Lowman, 1954; Margolies, 1959). The failure to follow a reliable and valid methodology can only lead to confusion.

The effectiveness of available therapy does not appear to affect the economic consequences of the disease. Patients with rheumatoid arthritis will continue to develop severe economic problems (Katz et al., 1968; Lee et al., 1974). Patients visit their physician about 12 times per year of which 8 were to a rheumatologist (Yelin et al., 1979) and medical costs for rheumatoid arthritis were three times the national average for all other diseases (Meenan et al., 1978). Financial problems may be a source of long term

psychological stress among rheumatoid arthritic patients (Rimon et al., 1977).

An awareness of the direct and indirect costs for individual patients should be taken into account when referrals are made by medical professionals in countries without free medical care or adequate insurance (Brattstrom and Larsson, 1983). In addition documented cost data need to evaluate the economic efficacy of treatment interventions. Research on the costs is important for shaping social policies on the available services (Anderson et al., 1985)

COMPLIANCE AND NON-COMPLIANCE

The characteristics and treatment of rheumatoid arthritic patients are typically associated with non-compliance. This is a result of treatments that are likely to be lengthy, the probable adverse side effects of drugs and the absence of short term benefits of therapy (Luntz and Austin, 1960; Porter, 1969; Masek, 1982). Both the physician and the patient are faced with a confusing array of medication, with no single one being unanimously recommended (Silverman 1975; Calin, 1978). The relevance of any therapy or combination of therapies for long term management are not known (Achterberger-Lawlis, 1982).

In this situation patients do not always comply with the physician's instructions especially if they have been kept waiting for treatment (Geersten et al., 1973). Estimates of non-compliance with medication have ranged from 22% to 67%, although some of these results rely upon self-report which are unlikely to be accurate (Geersten et al., 1973; Ferguson and Boyle, 1979; Belcon, 1984).

In the majority of investigations into compliance factors such as type of medication, duration of illness and disease severity have not been controlled. Other studies have found however, that compliance varies significantly as a function of these factors.. (Lee and Tan, 1979; Inui et al., 1980; Deyo et al., 1981; Litt and Cuskey, 1981). Poor compliance rates have been reported for drugs such as aspirin and indomethacin, while compliance rates for 2nd. and 3rd. line drugs such as prednisone and penicillamine have been satisfactory (Deyo et al, 1981; Inui et al, 1980). Patients with more severe rheumatoid arthritis or longer duration of the disease may be more likely to be poor compliers than those with relatively mild or recent disease onset (Lee and Tan, 1979; Litt and Cuskey, 1981).

The best remedy for non-compliance is to involve the patient in planning the regimen (Ehrlich, 1980). Physicians will need to reassess their prescribing practices in planning the regimen to take this into account. At present it would appear that it is the practice to alter individual non-steroidal anti-inflammatory drugs only in response to therapeutic failure. But in considering poor compliance rates these failures may not be caused by their unresponsiveness to the disease as is believed but may in fact reflect the patient's non-compliance (Belcon, 1984).

The lack of a medical cure prompts patients to try non-physician-prescribed medication. This is perhaps a more accurate description than alternative medicine. Physician-controlled-medicine only controls a part of health provision. There are a wide range of medical problems for

which a considerable number of medications are available from the chemist in addition to the medicines prescribed by the physician (Pal, 1986). Rheumatoid arthritis also resides in the area of generalised 'rheumatics' which is the subject of many folk remedies (Huigol et al., 1982; Nolan, 1983).

Patients in chronic pain are likely to turn to any form of treatment, orthodox or unorthodox, proven or unproven, if they believe it will help them (Baum, 1982). It is therefore important for the physician to understand the patient's beliefs and attitudes towards their illness when prescribing treatment (Jette, 1982). In one investigation 98% of patients had sought treatment from sources other than their physician and most patients had tried more than one treatment (Huigol et al., 1982). Caution is advised because many of the treatments cannot be shown to make a difference when measured by medical criteria and they can be potentially dangerous (Smith, 1979). Generally, arthritis sufferers^{ef}_A are the most exploited of all patients (Arthritis Foundation, 1976).

DOCTOR-PATIENT RELATIONSHIP

The doctor-patient relationship is of prime importance, not only for reasons of compliance, but because the patient cannot be compared with acute patients where the relationship is normally time limited. The clinical features of rheumatoid arthritis, its capriciousness, its chronicity, variable disability and potential to disfigure means that it affects all aspects of a patient's life making management a challenge. Patients and their doctors are involved in a long

term relationship in which the vagaries of the disease and normal life interact in a complex way (Rogers et al., 1982). Some patients complain that their doctor is too busy to spend time with them which does not allow a trusting relationship to be developed (Smith, 1979).

The evidence suggests that the physician should be aware of the patient as an individual and the physician needs to take time to understand the patient. There is probably nothing more destructive to the doctor-patient relationship than for the physician to quickly decide that the patient is a malingerer or hypochondriac. The patients should not get the impression that the physician thinks their pain is imagined (Labhardt, 1980). Although the impression may not be put into words it can be communicated to the patient by the physician's attitude and the quality of the care provided (Shamoian, 1980).

Investigations have demonstrated that physicians need to understand the attitudes and beliefs of their patients if a satisfactory relationship is to be established. It has been found that physicians overestimate the importance of non-traditional treatments and strongly underestimate the value of conventional medical treatments (Lorig et al., 1984) and that they underestimate the value patients put upon patient education (Potts, et al., 1984). The results of these investigations suggest that many physicians and other medical professionals may have highly erroneous beliefs concerning the treatment and other components of medical care that patients perceive as valuable. The insensitivity of doctors to their patient s'

values and beliefs may account in part for some patients' decisions to fail deliberately to comply with their medical regimen (Anderson et al., 1985).

DEPRESSION

Psychological problems occur in most patients with rheumatoid arthritis, including the fear of bodily disfigurement which results in them becoming crippled and dependent. The patients experience uncertainty about disease progression, concern about altered self-image, erosion of self-concept and the ability to cope with the feelings of frustration associated with the continued disease can lead to the patient suffering from depression (Rogers et al., 1982).

Depression is a generalised psychological problem which is found in many areas of human interaction. There have been many attempts to measure it and standardised instruments have been developed. They have been used in investigations into patients with rheumatoid arthritis. Many of these investigations have used the MMPI and although criticisms of it have been noted above the finding were consistent across the studies.

In one study a large sample of hospitalised patients scored significantly higher on the depression scale than those of control groups of general medical patients and healthy individuals (Polley et al., 1970). Samples of rheumatoid arthritic outpatients also had elevated depression scores which tended to fall between one and two standard deviations above the mean (Nalven and O'Brien, 1964; Wolff and Farr, 1964; Liang et al., 1984). Scores in

this range typically indicate mild, reactive depression and several studies have suggested that this represents an emotional reaction to chronic illness (Spergel et al., 1978; Baker, 1981).

When the depression scores of rheumatoid arthritic patients have been compared with other chronically ill patients, similar mild elevations have been found (Bourestrom and Howard, 1965; Spergel et al., 1978; Liang et al., 1984). However, it should be noted that many items of the depression scale relate to somatic problems that can result from chronic illness as well as depression. The elevation of rheumatoid arthritic patients may be partially explained by the illness itself (Smythe, 1984). Similar results have been obtained when the Beck Depression Inventory and the Zung Self-rating Depression Scale have been used (Zaphiropoulos and Burry, 1974; Gardiner, 1980). When these standardised instruments have not been used a similar position has been found that shows depression is a psychological concomitant of rheumatoid arthritis (Weintraub, 1974; Rimon, 1974; Robinson et al., 1977; Czirr and Gallagher, 1983; Allebeck et al., 1985).

It would appear that there is a close connection between depression and denial in rheumatoid arthritis. Denial is a common psychological defence mechanism. Patients who believe that rheumatoid arthritis is correlated with old age tend to deny the existence of disease symptoms. However because the disease is a chronic complaint the symptoms do not disappear and this can lead to depression when the denial of symptoms is no longer feasible (Wiener, 1975;

Rogers et al., 1982; Brooks and McFarlane, 1983).

Because depression is so prevalent in rheumatoid arthritis, physicians are used to seeing patients with it. This may lead to them considering the position as being normal. Textbooks will acknowledge that it is something they should be aware of and that it should not be treated with antidepressant drugs. The distinction is drawn between depression consequent upon the disease as opposed to endogenous depression, with features like early morning waking which are responsive to lithium (Capel et al., 1983).

ALEXITHYMIA

The concept of alexithymia (without words for feelings) has been suggested to be a factor in the psychological personality of patients (Sifneos, 1972, 1973, 1983). It has been suggested that alexithymia is an unknown genetic or developmental defect that theoretically disrupts the neuronal connections between the limbic system and areas of the neocortex and may involve the paleostriatal dopamine tract (Steven, 1973). Neural activity related to drive arousal is not processed through higher cortical areas. Feelings and conflicts are not articulated but might be translated into somatic pathways. The denial of emotions, the calmness and the repression often described in arthritic patients may stem from alexithymia (Lesser, 1981; Achterberg-Lawlis, 1982; Taylor, 1984; Krystal et al., 1986; TenHouten et al., 1986).

Alexithymia may also be connected with an inability to fantasise and patients who can fantasise do

better than patients who cannot. Patient's ability to describe their mood patterns appears to correlate with better coping (Moldofsky and Chester, 1970), also patient's ability to recall dreams (McLaughlin et al., 1953).

It has been suggested that rheumatoid arthritis has received little attention from psychologists (Genest, 1983), but the number of studies reported in this chapter does not substantiate this claim. However it is apposite to record that out of ten recent volumes that surveyed health psychology, only five made any reference to rheumatoid arthritis and none of them exceeded one page in length (Doleys et al., 1982; Lipowski et al., 1977; McNamara, 1979; Melamed and Siegel, 1980; Millon, et al., 1982; Moos, 1977; Prokop and Bradley, 1981; Stone et al., 1980; Stuart, 1982; Turk et al., 1982).

STRESS

Stress is not a component of personality but undoubtedly it is a psychological reaction to it. Stress is becoming increasingly recognised as a concomitant of a number of diseases (Rabkin and Streuning, 1976; Bartrop et al., 1977; Bahnson, 1981; Ben-Sira, 1981; Cohen, 1981; Anisman and Sklar, 1982; Cooper, 1984). Stress has been identified as a potential triggering factor in the aetiology of the autoimmune diseases (Weiner, 1977). Stress has been found to correlate with rheumatoid arthritis (Lichtenberg et al., 1984; Rimon, 1985). In a study of monozygotic twins, stress was found to be the factor that precipitated disease onset in the twin who contracted rheumatoid arthritis (Meyerowitz et al., 1968).

It is widely accepted that increased muscle tension is a consequence of rheumatoid arthritis and stress (Moos and Engel, 1962). In addition it is also accepted that muscle tension in rheumatoid arthritis can be produced by psychological stress (Morrison et al., 1947). States of fear and tension produce increases in intra-articular temperature which could exacerbate the already hypermetabolic condition of the disease and produce flares (Horvath and Hollander, 1949).

The relationship is not straightforward however, different definitions of stress are to be found in the literature. Some studies define stress as being an environmental stimulus whilst others take it to be a response. Several papers have investigated the environmental stress by recording stressful life events preceding disease onset. It was found that a significantly greater number of rheumatoid arthritis patients, than controls, had experienced life events with potential life long emotional consequences in the twelve months preceding disease onset (Levitan, 1981; Rimon et al., 1977). In one study only 14% of patients failed to report a negative relationship with their mother or a stressful life event before the onset of disease (Baker, 1982). Because of the nature of the studies it is difficult to tell whether stressful marriages are a consequence of disease or a cause.

It has been suggested that there may be important individual differences with regard to the role of psychological stress in the onset and exacerbation of rheumatoid arthritis. Two subgroups have been identified

within a sample that differed with respect to the presence or absence of psychological stress prior to the onset of the disease. The two subgroups were characterised as a major conflict group and a non-conflict group. The major conflict group were identified as having distinct acute rheumatoid arthritis following a psychologically stressful experience. They had rapid disease onset and there was no history of family involvement. The non-conflict group was distinguished by a large number of family members having rheumatoid arthritis, insidious disease onset and slow symptom progression (Rimon, 1969, 1981, 1985; Rimon et al., 1977).

The literature has consistently identified disturbed relationships as major stress factors among rheumatoid arthritis patients. The methodology of some of the studies was not very rigorous although others included controls. Stress would appear to be a factors in both the aetiology and pathogenesis of the disease.

SUMMARY AND CONCLUSIONS

The available research literature on the psychological concomitants of rheumatoid arthritis has been analysed. The concomitants have been shown to exist independently of the physical symptoms and are an integral part of a patient's approach to coping with the disease. It has been argued that whilst there is no specific arthritic personality various aspects of a patient's personality are involved in the challenge of coping with the effects of the disease. A number of these aspects have been examined. It

has not been suggested that the list has been exhausted, others could have been included.

The argument followed in the chapter was guided by two considerations. Firstly, the list could not be exhausted. A patient's response to the disease is an individual matter and cannot be circumscribed by a definitive set of factors. Secondly, this kind of investigation would tend to follow the scientific approach of breaking factors down into smaller components in the belief that ultimately one component will explain everything. This linear model of knowledge based upon the continuum encourages the reduction of problems into the smallest possible components and is thought to be one of the most highly developed skills of western culture and prized in science (Graham, 1986).

Most of the medical textbooks comment upon the fact that rheumatoid arthritis is characterised by periods of exacerbation and remission. The daily uncertainty of how the disease affects patients leads to stress and this will be illustrated by patients' comments reported in Chapter 5. Periods of exacerbation and remission would appear to be a particular identifier of the disease yet it is not referred to in the diagnostic criteria or the psychological concomitants. They could be used as a diagnostic criteria and it could be recognised that the concomitant psychological stress requires some form of therapy.

It is concluded from the weight of evidence produced above that there is a need for a therapeutic intervention for the psychological aspects of the disease

which at present is not being met. It will be argued in Chapter 3 that group counselling is a possible source of psychological support for patients.

THE PSYCHOLOGICAL THEORIES OF GROUP COUNSELLING

INTRODUCTION

The argument presented so far has been that rheumatoid arthritis has psychological concomitants. It has been argued that these psychological concomitants arise from two separate sources.

1) There was uncertainty and confusion surrounding the concept of rheumatoid arthritis. The lack of an accurate definition affected the medical treatment provided. It has been shown that there was no single standard and effective treatment. This position caused stress and anxiety for patients.

2) The physical symptoms of the disease gave rise to psychological concomitants. The symptoms of pain and stiffness can result in depression and reduced libido. In addition, the disease characteristic of periods of exacerbation and remission, can result in anxiety states and mood variation. The details of this argument were presented in Chapter 2.

It has been shown that the psychological concomitants of the disease have been largely ignored. There was a need for a therapeutic intervention to help patients cope with these concomitants which at present was unmet. This chapter presents the argument that group counselling

may be an appropriate therapeutic intervention.

The development of group counselling dates from the beginning of the Twentieth Century and was characterised by changes and alterations in theoretical contributions from different theorists and practitioners. Group counselling has been shown to be a therapeutic intervention for other diseases (Wilson, 1974), and in other areas (Nelson-Jones, 1982). A number of studies have evaluated group therapies as a therapeutic intervention for patients with rheumatoid arthritis. These studies use both group counselling and group psychotherapeutic models and without a knowledge of the development of both it would not be possible to understand their strengths and limitations (Henckle, 1975; Udelman, 1977; Schwartz et al., 1978; Udelman and Udelman, 1978; Kaplan and Kozin, 1981; Shearn and Fireman, 1985; Strauss et al., 1986);

Certain terms are used in the literature in specific ways. For example the word 'psychotherapy' acknowledges that its theoretical basis for group therapy was psychoanalytical. Psychotherapy implies a range of meanings which are different from group counselling which had its origins elsewhere. Both group counselling and group psychotherapy have distinct and different theoretical basis. However, recent developments have brought group counselling and group psychotherapy into closer contact, the terms sometimes becoming synonymous. These examples show that group counselling has been influenced and affected by different psychological approaches. The different psychological approaches can be considered under three main psychological theories. The three theories are



psychoanalytical, behavioural and humanistic.

This chapter describes these three main theories. Because each theory is influential they will be discussed in separate sections. Each section gives a historical account of the theory's development and each section has its own introduction. The information in each section is relevant to the development of the theory as it affects group counselling only and it is not intended to be a major historical analysis.

The chapter concludes that the three theoretical approaches all have valuable contributions to make to the practice of group counselling. However, because the group counselling is for patients with rheumatoid arthritis, who have the particular psychological problems discussed in Chapter 2, it is argued that the most appropriate theoretical foundation would be based upon humanistic psychology. This does not imply that the other theories are redundant. Strategies and techniques from the other theories will be used in an eclectic model of group counselling (Brammer and Shostrom, 1982)

Section 1

PSYCHOANALYTICAL PSYCHOLOGY

Introduction

Psychoanalytical psychology represents a particular view of human nature that relates to the development and structure of personality. Psychoanalytical psychology is both a theory of personality and a method of therapy. The development of theory and treatment progressed

concurrently. Freud was the first person to propound a unified theory of personality and the theory was that personality changed with the physiological maturity of sexual development.

Freud concentrated upon the inner thoughts and feelings of the mind. He divided the mind into three distinct areas, the conscious, the preconscious and the unconscious. The three states of mind were not absolute categories but points on a continuum varying from that which was clear and present to that which was completely hidden in the depths of personality (Nye, 1981). Freud was particularly interested in the unconscious and focused upon it as an area of study.

Freud maintained that there were three areas of the mind, the id, the ego and the superego. They all had different functions. The id contained the pleasure seeking centre of the personality, the superego contained the moral aspects of the person and the ego mediated between the two drives. So the ego was responsible for controlling the sexual and aggressive drives.

Psychoanalysis as therapy was concerned principally with coping with anxiety. The anxiety could arise from threatening circumstances connected with the external environment, the threatened breakthrough of repressed drives in the id or the threat of guilt and other uncomfortable feelings associated with the superego. The anxiety could be connected with mental defence mechanisms such as sublimation, repression, projection and denial which the mind used to protect itself.

The section starts with the first recorded example of using a group in a medical setting. It then investigates the development of psychoanalytical theory and its influence upon group counselling. It discusses its applicability to the psychological problems associated with people suffering from rheumatoid arthritis.

THE DEVELOPMENT OF PSYCHOANALYTICAL THEORY

Historically, groups have been a natural focus for inquiry but it was only in the Twentieth Century that they have been studied by a systematic methodology. During this century one of the questions that published studies have investigated was whether the provision of group therapy provides psychological support. The first recorded systematic study of groups used in this way dates to 1905 (Pratt, 1917).

Dr. J.H. Pratt of Boston designed a programme for poor patients suffering from tuberculosis. Pratt understood that one of the consequences of tuberculosis was that patients suffered social isolation because of the fear other people had of the disease. He understood that patients could be rejected by society and as a consequence emotional problems might arise. He appreciated that patients needed encouragement and supervision to cope with the challenge so he organised them into groups of twenty patients each.

Whilst in these groups, Pratt checked on their progress and made recommendations concerning diet, rest, and sleep. He showed them that even in a slum environment they could recreate some of the conditions of outdoor living emphasised in the sanatoriums. Pratt appreciated the

importance of a psychological atmosphere where mutual support could be given by patients having the bond of a common disease. He understood the beneficial influence that one patient, especially if he were improving in health, could have over the other members of his group.

It was this aspect that Pratt emphasised and his model for helping was a learning one. Pratt described it as a class method for treating tuberculosis in the homes of poor families. He appeared to adopt a pragmatic approach based upon a wish to improve the health of his patients. It is interesting that the first example of group therapy, concerned a physical illness. Nobody was to follow Pratt's lead for many years and although he was responsible for generating much interest in group work it was to be developed in the arena of psychological illness rather than physical illness.

After this first successful attempt group therapy was to concentrate upon psychiatric and social problems, based upon Freud's theories of psychoanalysis. Physical illness was not to be considered until the second half of the twentieth century.

During the period of Pratt's work, Freud had been developing his theory of psychoanalysis. However, none of Freud's practical work was concerned with groups and although he wrote about the subject he was never actively involved with them. With the exception of Pratt, little practical work had been attempted. The First World War was to bring a period of change because large numbers of soldiers returned from active service with psychiatric

problems. There were insufficient psychiatric staff to cope and a more economical and efficient system was needed.

In 1918, a psychiatrist, E.W, Lazell, used a lecture approach with war veterans diagnosed as suffering from schizophrenia. The approach was found to be effective and soon group therapy was extended to patients suffering from other psychiatric disorders. In conducting these groups it became apparent that the patients' overall adjustment to life was a legitimate focus of group attention and not just their specific psychiatric symptoms. During the turbulent post war period the practical necessities of group therapy were considered of greater importance than formal theory. Theoretical considerations tended to be overshadowed by a common sense approach emphasising the usefulness of instruction, advice, support and mutual identification among members. After the First World War, pressure for economical solutions eased and therapists had the opportunity of reflecting upon their experience.

GROUP PSYCHOLOGY AND PSYCHOANALYSIS

In 1921 Freud outlined a group psychology that was and still is relevant to the group psychoanalyst (Freud, 1953). It started from the premise that no individual had an understanding or complete knowledge of themselves unless they had undertaken a course of psychoanalysis.

Psychoanalysis was based on the assumption that the antecedents of current behaviour could be dated to an individual's past and invariably their childhood. Freud believed that until everybody had been through the process of psychoanalysis they were not able to understand their own

behaviour.

The fact that individuals consulted experts to be given the solutions to their problems resembled the medical model. This explained why therapy based upon psychoanalysis could be accommodated into scientific medicine. Another feature in common with medicine was that patients were referred for treatment and this supported the premise that they are sick. The referral depended upon a diagnosis by an expert. In this way psychotherapy was seen as remedial provision. This development lead to the concept of psychopathology which was the aetiology and pathogenesis of diseases of the mind. Freud recognised that the legitimating force of science could do much to establish psychoanalysis as the science of the brain (Grunbaum, 1985). This approach did not meet universal approval. Psychoanalysis and psychopathology lead to the establishment of the profession of psychiatry. It soon encountered criticism.

'The psychiatrist has expanded the domain of mental illness to include all degrees and kinds of psychological distress. Failing to appreciate that the human suffers pain not because he is sick but because he is human.'

(Szasz, 1979, p. 9)

Adler (1921) by contrast believed in the need to consider social factors in treatment and he used the group format in child guidance centres and also with alcoholics and criminals. It was within the child guidance clinics that Adler was to formulate and develop his theories. Adler encouraged children to discuss their problems in front of

adult audiences and defended this approach by arguing that the child came to see *his* difficulty as a community problem. The adults also began to learn and understand the child's perspective. By using this method Adler laid down the basis upon which group counselling was to be developed (Ansbacher and Ansbacher, 1956).

Freud was not to make as much progress or impact with group psychoanalysis as he made with individual psychoanalysis. He did not feel that the two psychologies were different. He maintained that it did not make sense to consider the individual, except in relation to other individuals, so psychology was essentially group psychology. He wrote that a group could be as small as two members and that he was able to link individual and group psychology together.

Although much of the writing on psychoanalysis was applicable to the group situation Freud was also to devote some of his time to group psychoanalysis. His contribution was an important one and forms the basic psychoanalytic foundation on which the subject rests. Much of his thinking derived from the meetings of the group of psychoanalysts who surrounded Freud in the early days of the Vienna Psychoanalytic Society (Nunberg, 1962). Some of the group did not agree with Freud, for example, Jung had a distinct bias against groups because he saw psychological illness as an individual experience and therefore he argued that patients required individual treatment.

ISSUES IN GROUP PSYCHOLOGY

Freud became interested in trying to resolve a

number of issues relating to group psychology. He focused upon the definition of a group, its leadership, its cohesiveness and sense of identity. Freud maintained that a collection of people was not necessarily a group but given the proper conditions it could develop into one. Freud distinguished between transient and permanent groups, homogeneous and heterogeneous groups, natural and artificial groups and organised and unorganised ones, but his major differentiation was undoubtedly between leadered and leaderless groups.

Freud believed that leadership was a crucial aspect of group life. He argued that what brought an individual into the group was its leader. However, this was essentially different from what brought the leader into the group. There were two basic dynamic drives within group psychology. They were the psychology of the individual members and the psychology of the leader. Freud maintained it was these two psychologies operating in every group that made group psychotherapy twice as complicated as individual psychotherapy.

Identification was one of the basic features that exercised an influence over the members of a group. The group members identified with the leader whom they viewed as a surrogate father and they also identified with one another through their commitment to the leader. Freud argued that a second important factor was empathy, which enabled the group members to experience their group life through one another and to obtain an inward experience of another's mental life.

According to Freud, a group's cohesiveness emerged

from elements such as identification, empathy, relatedness, sympathy, common purpose, mutual interests and more fundamentally, a recognition of something common that incorporated and was shared by all the members. These were the factors that were to be developed by later writers.

Freud's analysis was influenced by the same factors that affected his analysis of psychoanalysis. Freud maintained that some of the narcissism of the members was projected onto the groups so that it became something very special and some of it was projected onto the leader making him an ego ideal. Under conditions of charismatic leadership the group may become hypnotised, surrendering to the superior power of the leader. The members may then show a marked dependency and submissiveness, a set of circumstances frequently seen in psychotherapeutic groups.

The more a group developed the characteristics of a powerful group, the less they needed dominant leadership. Conversely, the more leader-centred the group became, the more regressive its organisation. When a group with a strong leader, lost its leadership, a dissolution of identity occurred and the group became fragmented. The members stopped listening to one another and a loss of cohesiveness ensued. If the group failed to select a new leader it would cease to function.

Group psychology recognised that man was a social animal born into a group, who lived within a group and usually died supported by a group. Psychologists maintained that man, like other gregarious animals, felt incomplete when he was alone. Freud argued that there were also deeper forces that kept a group together, but they concerned erotic

impulses, although Freud had less to say about them. He hypothesised that homosexual love was far more compatible with the maintenance of group cohesiveness than was heterosexual love. Both love and neurosis he saw as having a disintegrating effect on the group.

Freud became aware of the therapeutic effects a group could have for patients with neurosis. He noticed that individuals with a strong impulse to form groups soon reduced their neurotic behaviour and it eventually disappeared. He observed that well organised groups were a powerful protection against the development of neurosis and that when an individual was expelled from the group he was compelled to replace the group formations by neurotic symptoms. Freud was therefore interested in using groups to therapeutic effect.

It was on the basis of this theoretical background that psychotherapeutic groups were to develop. Freud never put his theories into practice and so the work of testing them was left to others. The practical therapists based their initial analysis upon the basic tenets of psychoanalysis which were, transference, resistance, free association and catharsis. The development of Freud's theories did not reflect the particular needs of rheumatoid arthritis patients as outlined in the previous chapter although they did apply to sexual problems. Freud's theories did lead to the development of

'a conglomerate of methods and theories having diverse multiple origins in the past, and resulting inevitably from social demands, and

developed in various forms by many persons'
(Corsini, 1957 p.9).

Freud influenced Burrows (1927) who was interested in psychoanalysis and its application to group treatment. Like Freud he noticed that many of the characteristics of psychoanalysis could be found in groups. Patients were able to verbalise actual fantasies and family conflicts and even able to manifest defence and transference mechanisms.

Burrows treated patients in groups because he felt that they were less resistant to treatment in a group setting. Within the group, the patient became aware that they shared many things with other members. Patients realised they were no longer alone and that their problems were no longer unique. They began to appreciate the support of the group and no longer felt the need for isolation or secrecy.

Burrows tried to see the patient s'problem in their wider social context. He was reluctant to define patients as people in need of help. He also thought that psychoanalysts should not be seen as experts who provided solutions to their problem. Burrows saw both as elements in a sick society needing to understand the social phenomena from which they were suffering. This therapeutic role concerned with negotiation, compromise and empathy was to be taken up later with the position of group counsellor. Burrows stressed the importance of the here-and-now and paid little attention to the hereditary or genetic aspects of the patient s'problems. This was a new development in psychoanalysis which was so used to interpreting problems in the light of childhood experiences.

In many respects Burrows moved away from his psychoanalytical training and he encouraged characteristics which were to be precursors of group counselling. He emphasised the benefits of an atmosphere which supported a group in which spontaneity, immediacy and process were at the centre. He tried to bridge the gap between words and feelings and he tried to get all of the members of the group to recognise that verbal expression was not always an accurate expression of how a patient felt.

Burrow's groups discouraged self consciousness, secrecy, making judgements of others and they were conducted in a supportive atmosphere. In the groups, the patient's social image came under scrutiny, they were helped to see beyond this image and discover the resistances that prevented them from examining their consciousness. Once the members of the group had penetrated the social image and confronted the resistance, the individual was able to function at a more preconscious level. It was appreciated that resistance could work in a variety of different ways (Collison, 1984). This change found expression in a quiet self possessed mood.

In 1932 the term 'group psychotherapy' was coined by Moreno and it acknowledged the interest and importance that was now being given to groups. Some of Burrow's work was replicated by Wender in 1936 (Wender, 1940). Wender conducted group psychotherapy in a hospital setting with psychiatric patients. He found that patients were able to experience therapeutic movement more freely in the group situation. He found that transference relationships

developed within the group both for the therapist and other patients. He further found that patients in groups appeared to be better motivated than patients in individual therapy. This finding was supported in cases of physical illness and therefore becomes a practical consideration as a therapy for patients suffering from rheumatoid arthritis (Brautigam and Ruppell, 1977). His observations showed that groups had a therapeutic effect upon patients, apart from lowering their resistances and increasing their spontaneity.

Wender was an exception among pre-war analysts because he was interested in the dynamics of the group. He tried to identify the factors that were therapeutic for group members. He identified four factors. Firstly, intellectualisation which was a patient's understanding of his own emotional reaction and this facilitated greater self awareness. Secondly, transference which can be more widely exploited in groups than in classical psychoanalysis. Thirdly, therapist and patient represent parent and child and can re-enact childhood traumas. Finally, interaction which develops in the patient a changed perspective on his own behaviour.

At the same time Schilder (1936) was also working with psychiatric groups. Schilder was interested in the patient's sense of body image. Schilder maintained that the image a patient developed of his own body played a major part in his psychological sense of well-being. Any injury to the body had an effect upon the patient's body image. It was noted that this referred to injury and not to the slow insidious changes that can occur to the joints of a rheumatoid arthritic patient.

The exploration of these changes in body image was

especially suitable to the group situation. The patients shared with others the basic problems of their life and faced the comments and criticism that they provoked. From the information discussed in Chapter 2 it would appear that this situation would be therapeutic for patients with rheumatoid arthritis. The group discussion often started on a intellectual level but gradually became more personal and emotional. When others are able to identify with a particular aspect of a patient's problem the patient was better able to work through the problem. This method tended to emphasis the process of what was developing with no attempt at scientific measurement.

Under the influence of Burrows, Wender and Schilder, group psychotherapy was viewed increasingly within the conceptual framework of psychoanalysis, which was already established as a theory of individual personality. Wender and Schilder adopted the small lecture room setting, which dated back to Pratt. They read out case histories of patients who had been analysed as a starting point for group discussion. This emphasis upon psychopathology would not appear to be relevant to patients with rheumatoid arthritis. Both were psychoanalysts and both were impressed by the tendency of the patients to become increasingly involved with each other. Although the major thrust was psychoanalytic the influence of Pratt's early model could be discerned.

Burrows referred to his procedures as group analysis, Wender observed that transference phenomena developed within groups just as in individual analysis and

Schilder incorporated the Freudian technique of free association into group psychotherapy. They adopted and adapted psychoanalysis to the group situation rather than evolved any new theory about groups. They worked in the USA where psychoanalysis was readily accepted, unlike England, where it was not welcomed into academic medical circles.

GROUP PSYCHOTHERAPY

Interest in group psychotherapy was pursued independently in the USA and UK. In both countries the Second World War was to focus attention again upon the economic and efficient use of limited supply of therapists. The problem arose over the treatment of large numbers of soldiers returning from the conflict with psychiatric problems. Providing treatment in group settings proved to be the most effective use of limited resources. Two of the main topics that were to develop at this time were the length and number of group meetings and the optimum number for a successful group.

In the USA, research was conducted by Slavson (1950), and Wolf and Schwartz (1962). They were to apply psychoanalytical concepts, particularly resistance, transference and interpretation to the group situation. Although they acknowledged that the presence of other patients added an extremely important variable to the treatment process, these analysts insisted that the diverse and complex phenomena of the group situation could be accounted for by psychoanalytical concepts. They were particularly interested in transference where patients

became aware that their current attitudes toward the group leader and other people were affected, both by a defensive resistance to awareness and insight, and to their earlier, often fearful, memories of childhood.

Group psychotherapy offered a number of alternative approaches in which those attitudes could be explored. It was realised that the most effective treatment and therapeutic interpretations for patients were ways that allowed current emotional attitudes to be connected with important figures from their childhood. Slavson, Wolf and Schwartz coined the term 'multiple transference' which referred to the fact that a patient's transference was not only concerned with the group leader, but to other members of the group as well. They also claimed that in group psychotherapy the most important person was the individual patient. Even though treatment was in a group setting the therapist could concentrate upon one patient at a time and not the group as a whole.

The three psychoanalysts recognised the importance of the same general principles but they did not always agree upon the benefits of group psychotherapy. Slavson argued that transference could not be as intense in groups. He also maintained that interpretations of patient s'problems could not be analysed as deeply as in individual psychoanalysis. Wolf believed the opposite. He argued that group situations often allowed for deeper analytical exploration than was possible in individual psychoanalysis. The reason, he maintained, was that the group achieved a cohesiveness with which each member came to identify and it offered the

necessary support for deeper exploration. As each member became a source of support for each other they were able to cope with greater levels of anxiety. In addition, after a certain amount of group experience, each member became skilled enough to offer their own analysis of a patient's problems.

A concurrent area of innovation was to try and develop a sequential framework of discrete stages through which patients would pass. Since Freud's early suggestion that the period of psychoanalysis could be divided into an opening, a middle and an end, various therapists had tried to distinguish a natural development. Wolf's interest with a group's development was new and would be taken up by many theorists after him. Group dynamics became an important focus of study for him and this concentrated attention upon the here and now and not upon the past. The emphasis was still upon the individual as the focal point of interest although this was different from the developments taking place in the UK. In the UK the patients were hospital based, therapy sessions were held daily and the problems dealt with were psychiatric. Whilst it is acknowledged that patients with somatic complaints might also benefit, there are other models which could be more appropriate. These developments are of obvious interest and could provide a valuable source of psychological support for patients with rheumatoid arthritis.

In the UK the practical studies of Foulkes (1948), Ezriel (1950), and Bion (1961) concentrated upon different aspects of group therapy. They were still psychoanalytic in orientation and their focus of interest developed from

working with soldiers during the Second World War at the Northfield Military Hospital. A method was urgently required to cope with the very individual psychiatric problems found among the soldiers. Northfield became a major centre for innovation and Bion and Foulkes tried out new approaches to group therapy. They actively promoted the small group, which was to have a profound influence upon psychiatry. Bion's later work was to influence therapists at the Tavistock Clinic in London which gained an international reputation.

Bion was essentially a theorist and he attempted to establish universal laws of group behaviour and development similar to Wolf. He argued that all groups were characterised by a delicate balance between progressive and regressive forces. In group therapy sessions, the patients were encouraged to examine carefully their own behaviour and feelings. The process of self exploration would allow patients to better understand their underlying transference, therefore the group as a whole was encouraged to take the place of the patient. The more sophisticated use of transference and countertransference increased the therapeutic effectiveness of this factor (Flapan and Fenchel, 1984). The group was treated very much like an individual patient. This was an important development from Freud's earlier comments about group cohesiveness being a therapeutic factor.

Bion had established that three factors in particular were important in the group process:

- 1) that there existed a group unconscious in which all members participated in some form;

- 2) that irrational and even psychotic processes naturally emerge in all groups;
- 3) that psychoanalysis uncovers the complex relation between the socio-emotional and task-oriented aspects of group life (Pines, 1985).

While Bion was influencing the Tavistock Clinic, Foulkes was influencing the London Institute of Group Analysis. He was interested in group psychology and made important contributions to the knowledge of group dynamics and group identity. Foulkes maintained that the group in practice included a genuine, organised and dynamic identity that had its own existence. Once the group had met for several sessions it acquired its own identity which was separate from and independent of that of its members. However, the concept of an organised and coherent group identity was a hypothetical construct with no physical reality that it could not be tested or verified. It was accepted generally that the effect the group-as-a-whole has upon the individual members was dynamically different from the effect that individual members have upon one another and from the effect that members have separately upon the group (Agazarian, 1983).

In the same way that an individual's personality could be seen as a set of 'selves' so the group could be viewed as a set of persons or individual selves. Therefore, the behaviour of any one person in the group could not be seen as independent from the behaviour of any other person or from the group as a whole. This contradicted the earlier work of Slavson, Wolf and Schwartz mentioned above.

By the end of the Second World War the study of

group therapy was becoming much more diversified and a more complete understanding of group dynamics and developmental stages was evolving (MacKenzie and Livesley, 1984). The exigencies created by the war had firmly established that psychoanalytical practice could be transferred from individual therapy to the group situation and more patients benefited from the group situation than from individual psychoanalysis (Campbell and Sinha, 1983). Foulkes was impressed by the therapeutic power of the group process and he began to identify the factors that were responsible for it. He illuminated 5 factors:

- 1) acceptance- a member feels understood and equal;
- 2) universality- the member senses others have similar problems to their own;
- 3) vicarious learning- a member may learn through another patient's therapy;
- 4) guidance- the exchange of information;
- 5) cohesiveness- the sharing of free associations.

These factors concentrated upon group identity. This caused Foulkes to look for adequate models that would account for the dynamics and behaviour he observed within the group. A model had been developed in Lewin's field theory which was to be influential in both psychoanalysis and humanistic psychology.

LEWIN'S FIELD THEORY

Lewin's field theory postulated that a person's dynamics and behaviour were intimately bound up with the nature of the social forces around him. Lewin, who was a

social psychologist, argued that it was not possible to understand an individual's behaviour without taking into account his total environment. The individual could not be understood as a solitary figure unlike the theory of Jung and other psychoanalysts. The complete 'landscape' had to be taken into consideration, this was an idea which was reflected in the theory of Perls. Lewin's was interested in many social issues and he developed and was dedicated to action research. He did not want to contribute directly to group psychotherapy but his influence can be seen in the work of other practitioners who adapted his ideas to group situations.

Lewin's argued that each individual member of a group struggled for adequate space in the way that animals struggle for territory and it was inevitable that the needs of any particular member conflicted with the needs of the group-as-a-whole. The group always demanded some sacrifice on behalf of its members and some limitation on their space for free movement. The amount of conflict generated, varied directly with the amount of restriction imposed by the group as compared with the amount of mutual support and involvement that individual members received in exchange. How the members of a group coped with the tension depended partly on the structure of the group and partly upon its leadership.

It was possible to postulate a continuum of two opposing theoretical positions. In one, the group was poorly organised, weakly integrated and leaderless, tension was poorly distributed and tended to rise to disruptive levels. In the other, the group was well organised, well integrated

and well led, the tension was more evenly distributed and communication flowed more smoothly. Most groups could be accommodated at a point on the continuum. In every group there was a balance of cohesive and disruptive forces and the level of tension depended on which factor was paramount. Under satisfactory leadership the tension within the group remained optimal allowing for constructive group activity.

Lewin maintained that group leadership was a function of group dynamics and created an atmosphere which was characteristic of the leadership style. The leader could effectively create this atmosphere but the atmosphere in turn may create the leader so that leaders tended to emerge spontaneously from different group situations. The members of the group also brought into the group with them the status that they had outside it and the roles that they played normally, which was similar to the concept of transference. Unless new roles were assigned to them in the group they would attempt to affirm their usual roles and manipulate other group members into supporting their habitual role activity.

Like Freud, Lewin saw the leadership role as perhaps the most complex of the different roles open to group members and appreciated that it might take different forms. The leader could be required to fulfil a numerous range of functions either singly or in any combinations including, co-ordinate the group's activities, control its internal relationships, symbolise its unity and integration, take the blame for its failures, assume

the place of the father in the lives of its members, act as arbitrator in conflicts, display expertise on all matters and serve as a model for appropriate attitudes and behaviour. In addition the leader was expected to take full responsibility for the present and future life of the group but that might be an unrealistic expectation because of the limited power of the leader.

'Because psychoanalytical theory deals only with personality structure, the group therapist has no way of changing the structure of the group as such; yet that change is essential if the group-as-a-whole is to serve its full therapeutic capacity. (Durkin, 1982, p. 443)

In the psychoanalytical movement the practical effect of Lewin's influence was that the group therapist now carefully observed the group interaction to discover the theme or group tension that was common to all the patients. This group process carefully nurtured and guided by the therapist was seen to be the significant curative factor in treatment rather than insightful interpretations directed toward a single patient. The therapist's task was to attend to group process variables as much as to the content of individual members concerns. Only by doing this successfully would the leader make interventions that would keep group tensions and group avoidances in a state of optimum balance where members would feel encouraged to express themselves but not at the cost of overwhelming anxiety or threat (Morran, 1982). This may not be appropriate in the case of patients with rheumatoid

arthritis. These developments were effectively practical rather than theoretical and could be applied to other group psychological theories, as will be seen in humanistic psychology.

Less emphasis was now to be placed upon theoretical development and more concern was to be shown to practical studies and territorial issues (Tuckman and Jensen, 1977). The theoretical basis of group psychotherapy had been established and concern was now shown^{as} to how it might be taught and practised. Group psychotherapy was still used mainly for psychiatric patients in hospitals and as such fell firmly into the domain of psychiatry.

In 1971 the Royal College of Psychiatry was given its charter. This formal recognition legitimised the practise of psychotherapy. The Royal College of Psychiatry controlled the training of psychotherapists for both general hospitals and specialised psychotherapy. Its training was concerned with both individual and group psychotherapy with increasing emphasis being put on the value of the group experience (Pilgrim, 1983).

Although the idea of therapeutic factors had received some attention from Foulkes it was not until the review of Corsini and Rosenberg (1955) that the central issue of what made groups therapeutic was considered. They reviewed the literature, some 300 articles, and extracted what appeared to be the therapeutic elements. They listed nine factors:

- 1) acceptance- a sense of belonging, being emotionally supported and accepted by the

group;

- 2) altruism- a sense of being important in the lives of other patients by helping them;
- 3) universalisation- the realisation by the patient that he was not unique and others shared similar problems;
- 4) intellectualisation- the process of learning or acquiring knowledge;
- 5) reality testing- the evaluation by the patient of personally held concepts;
- 6) transference- strong attachments to either the therapist or group members;
- 7) interaction- the opportunity for relating

within

the group;

- 8) spectator therapy- the patients gain. by observing others;
- 9) ventilation- the release of feelings and expression of ideas previously repressed.

Corsini and Rosenberg (1975) were the first to list as a discrete set of factors the therapeutic effects of group membership. The attempt was to be improved upon by Yalom (1975) who considered clinical observation, theoretical formulation and systematic research in an attempt to arrive at a classification and understanding of therapeutic factors. Yalom extended the list to twelve factors and this in turn was to be revised by Bloch and Crouch (1985) to ten:

- 1) insight (self-understanding)- where the patient learns something important about himself;

- 2) interpersonal action- where members relate more sensitively, intimately or assertively to each other;
- 3) acceptance (cohesiveness)- being emotionally accepted by the group;
- 4) self-disclosure- where patients revealed information about their life, outside the group;
- 5) catharsis- the release of pent up feelings;
- 6) guidance- being given help with personal problems;
- 7) universality- patients appreciated some problems were common to the group;
- 8) altruism- becoming important in the lives of others through helping them;
- 9) vicarious learning- understanding the course of other members' therapy;
- 10) instillation of hope- believing that improvement was possible.

When groups other than psychoanalytical groups were included in reviews the number of curative factors were reduced. The most consistent curative factors were, interpersonal learning input, catharsis, cohesiveness and self understanding (Butler and Fuhrman, 1983).

Bloch and Crouch (1985) reviewed 95 case studies in arriving at their list of ten therapeutic factors. None of the cases in their sample was concerned with physical illness. As was seen from the list most were concerned with psychological aspects of behaviour. Whilst it was evident that some of these factors would be necessary in all groups

if they were to have stability some are not particularly relevant to cases of physical illness (Cordiner and Wilson, 1982).

These therapeutic factors were still firmly based upon psychoanalytical theory. As a consequence of the developments that have occurred this century the framework of psychoanalytical theory has become less rigid and other influences have had an effect (Spitz, 1984). In some respects these new developments have weakened the logical strength of the argument for psychoanalysis but the increasing flexibility has allowed it to adapt to new situations (Kernberg, 1975; Kohut, 1977; Fried, 1980; Durkin, 1982). Conversely psychoanalytical theory has had an influence on other branches of psychology, particularly upon behavioural psychology as will be described in the next section.

Although psychoanalysis had provided the theoretical basis of psychotherapy that had been practised during the century it was not the only model available. It was tempting to believe that psychotherapy followed the development of psychology and it certainly would provide an academic neatness that would be intellectually satisfying. However this was not the case. Although psychotherapy did follow the academic development of psychoanalytic psychology to behavioural psychology and to humanistic psychology there was sufficient work going on that shows there were other important developments. Psychoanalytic psychology was to develop into an existential model for therapy with the work of May, Szasz and Laing and this major break would allow other models to be developed but

it was not to suggest that other developmental work had not been going on (Fried, 1985; Stone, 1985).

SUMMARY

The development of psychoanalytical theory has been given. It has had a dramatic impact upon psychology in the twentieth century and has been responsible ^{for} far-reaching change. However, it would appear to have a number of shortcomings as a theoretical base for providing psychological support for patients suffering from rheumatoid arthritis. These shortcomings can be summarised:

1) ignoring the body and its effect on the mind was a fundamental omission of psychoanalysis (Pietroni, 1986);

2) psychoanalysts appear to have a benign and paternalistic approach towards patients. They treat them as being in need of help. This approach would be unsuitable for patients with a strongly focused somatic complaint (Price et al., 1983; Room, 1984);

3) there was an emphasis upon the past, particularly childhood, as the causative agent of the present problem. Evidence would suggest that a causative factor of rheumatoid arthritis was the recent events and not childhood (Rimon et al., 1977; Levitan, 1981; Baker, 1982);

4) patients with rheumatoid arthritis suffer stress caused by an internal physical change. Psychoanalysis was directed towards psychiatric problems caused by external events (Lichtenberg et al., 1984; Rimon, 1985);

5) many of the patient s' problems stem from practical problems such as economic factors which

psychoanalytical theory does not seem to take into consideration (Katz et al., 1968; Lee et al., 1974; Rimon et al., 1977; Meenan et al., 1978, 1981).

6) psychotherapy could have an influence and effect upon the physical course of rheumatoid arthritis but psychoanalytical theory does not easily accommodate this idea.

For these important reasons psychoanalytical psychology was not suitable as the major theoretical basis for the group counselling. Many of the techniques of psychoanalysis were useful and were used. The interpretation of the group counselling process was helped by the use of psychoanalytical concept such as resistance which will become apparent in Chapter 5.

Section 2

BEHAVIOURAL PSYCHOLOGY

Introduction

Behavioural psychology approaches man from a more rigorous scientific standpoint than psychoanalytical psychology. It has been argued that psychoanalytical and behavioural psychology should be more closely integrated but a theoretical way of amalgamating the different key constructs has yet to be found (Arkowitz and Messer, 1984). Behavioural theory makes few assumptions about human nature. Its focal point was not the individual but the interaction that took place at the interface between the individual and his environment. Behaviour theory was concerned with the way in which that interaction could be understood, controlled and altered.

Behavioural theory concentrates upon the stimulus-response model of interpreting behaviour. It was interested in investigating what stimulus brought about what response. The development of the theory was promoted by experiments conducted according to scientific research methodology. The experiments concentrated upon isolating small pieces of behaviour and by controlling the independent variable, measured its effect upon the dependent variable. The early experiments concentrated upon the stimulus and became known as classical conditioning. Later experiments concentrated upon the response and they became known as operant conditioning which was influential in behaviour

modification. Most of the experiments were conducted upon animals in laboratory conditions and the results of the experiments projected to humans.

This early approach to behaviour theory led to behaviour modification which was concerned with the ways in which it was possible to alter behaviour. It investigated the concept of reinforcement which was the key to how it was possible to control and alter behaviour. Behaviour changes could be affected by either positive or negative reinforcement. Adopting the principle of reinforcement behavioural psychology examined the environment to discover how behaviour was shaped. Later theorists were to argue that this approach was too simplistic and the social context in which behaviour took place had to be considered. Social learning theory emphasised that behaviour patterns were complicated and social factors were influential in determining how a person behaved.

The behaviour theorists also came to appreciate that through behaviour modification it was possible to shape behaviour. The process of shaping behaviour allowed behaviour theory to be used as a means of therapy. Dysfunctional behaviour was made extinct and new behaviour patterns were substituted. The techniques of behavioural therapy such as feedback, relaxation therapy, role play, desensitisation and social reinforcement could be used as part of a group counselling intervention. This section gives an account of the development of behavioural theory as it applies to counselling.

BEHAVIOURAL PSYCHOLOGY

Behavioural psychology has its roots in the biological sciences and therefore has antecedents which determine much of its methodology, concepts and boundaries. Behavioural psychology has been influenced by the Cartesian-Newtonian paradigm which was discussed in Chapter 1. This paradigm has been dominant for the last three hundred years and has influenced most aspects of western culture, including moral sciences:

'The backward state of the moral sciences can be remedied by applying to them the methods of physical science, duly extended and generalised.'
(Mill, 1843, p. 265)

It has been accepted generally that the physical sciences were relied upon to establish cause and effect relationships that led to the foundation of beliefs and facts. This process was adopted by behavioural psychology so its methodology did not spring from the observation of phenomena but it was imposed by the rigours of the physical sciences.

'its institutionalization preceded its content and its methods preceded its problems....The scientism that many see and decry in recent psychology was thus with it from the start... From the earliest days of the experimental pioneers, mans' stipulation that psychology be adequate to science outweighed his commitment that it be adequate to man.' (Koch, 1959, p.783)

Science is viewed generally by scientists to be the highest achievement of western culture. It has its foundations in a linear model of knowledge, based upon the concept of the continuum. Implicit within the concept of the continuum was the notion of absolute truth or a fixed reality which in turn depends upon the concepts of measurement and ratio, rationality and reason.

This rationality and reason lead to an early commitment to scientific method, measurement and evaluation. Behavioural psychology became a form of the mechanistic view of man where human behaviour was not merely observed and interpreted, but an attempt was made to control behaviour in much the same way that the physical scientist sought to control and manipulate the subjects of his experiments in laboratory like conditions.

The scientific approach to behavioural psychology has had a pervasive influence over it, particularly its approach to research. Research methodology has followed the hypothetico-deductive model. This model emphasised aspects like measurement and control groups, independent variables and dependent variables and sought to establish what changes could be attributed to the experimental intervention.

This approach when applied to human behaviour was to be criticised.

'Our devotion to rigorous hard-headedness in psychology, to reductionist theories, to operational decisions, to experimental procedures, leads us to understand psychology in purely objective rather than subjective

terms.' (Rogers, 1969, p. 85)

CLASSICAL AND OPERANT CONDITIONING

This objective scientific approach regulated the experiments that were to lead to the psychology of behaviourism. The experiments were primarily physiological and biological. They started with Pavlov who was investigating the function of the brain. Pavlov was interested in the physical reflexes associated with the brain and how they affected behaviour. Pavlov maintained that all behaviour consisted of responses to stimulation. Following this model, he embarked on a series of experiments, using the salivary response in dogs to assess various stimuli. His classical model of altering behaviour by pairing a conditioned stimulus with an unconditioned stimulus showed how behaviour could be altered. The classical conditioning experiments were conducted in laboratories and showed that the behaviour of animals could be changed in a predetermined manner. Pavlov was not a psychologist and he did not try to repeat his experiments with humans. His interest was primarily biological and physiological and he did not replicate his experiments using human subjects.

Pavlov's work was continued by Watson, an American psychologist who was principally interested in behaviour. Watson adopted a rather tautological and non-specific definition:

'the subject matter of human psychology is the behaviour of the human being.' (Watson, 1931, p 2)

Watson maintained that psychology was a purely objective experimental branch of biological sciences. He argued that its main aim was the prediction and control of behaviour. This mechanistic and theoretical approach could not incorporate or accept concepts such as free will and consciousness. The experiments on Pavlov's dogs had been conducted and regulated without worrying about their consciousness or free will. Watson argued that the same conditions should attach to man:

'the behaviour of man and the behaviour of animals must be considered on the same plane; as being equally essential to a general understanding of behaviour.' (Watson, 1913, p.176)

Watson's interest lay in the stimulus-response pattern of behaviour but he appreciated that behaviour was not only biologically or physiologically controlled. He realised that humans altered their behaviour through interaction with the environment. The stimulus-response pattern provoked a response which usually involved movement or altered behaviour. This pattern, Watson argued, was accounted for by a learning model of behaviour. Watson believed that the majority of behaviour was learned. He concluded that if it had been learnt it could be unlearned and therefore altered. Watson was a determinist and he viewed behaviour in a mechanistic way

'the child or adult has to do what he does do. The only way he can be made to act differently is first to untrain him and then to retrain him.' (Watson, 1931, p. 183)

Watson, adapted Pavlov's classical model. He distinguished between learned and unlearned responses and thought that most behaviour was learnt. Watson's model of conditioning concentrated upon altering the response and became known as operant conditioning. Watson regarded behavioural psychology as an objective experimental branch of the biological sciences that focused on the behaviour of human beings (Watson, 1931). Behavioural psychology represented in an extreme form the mechanistic view of man, insisted that the psychologist's interest in human behaviour was not merely the interest of a passive observer but an attempt to control stimulus-response patterns in much the same way that physical scientists sought to manipulate natural phenomena (Wolpe, 1958).

Skinner (1953, 1973) was to develop Watson's work on the theory of operant conditioning. Skinner accepted that people were born with a reservoir of elementary biological impulses but maintained that after that behaviour was learned. Skinner adopted a stimulus-response model where behaviour resulted from drives that were physiological. After these elementary drives the environment was thought to influence behaviour. The reservoir of behaviour tended to become generalised so that similar stimuli evoked the same response. An individual's repertoire of behaviour was learned by interaction between the individual and his environment. Satisfactory behaviour was generally reinforced by operant conditioning which rewarded behaviour when it occurred. Skinner observed that a response which had occurred could not be predicted or controlled, but all that could be predicted was the probability of a similar response

occurring in the future.

The unit of a predictive science of behaviour was an operant. The term 'operant' emphasised the fact that behaviour operated on the environment to create outcomes. Thus the consequences defined the properties with respect to which responses were viewed as similar. Skinner acknowledged that Pavlov called all events which strengthened behaviour in his dogs 'reinforcement' and the resulting changes in their voluntary and involuntary behaviour 'conditioning'. However, the critical difference was that in Pavlov's work the reinforcer was paired with the stimulus, whereas in operant behaviour it was contingent upon the response.

Classical and operant conditioning were the only two possible kinds of conditioning. Behaviour that was reinforced tended to be repeated and became an established part of an individual's reservoir of behaviour. Negative reinforcement consisted of removing a stimulus, such as a bright light or electric shock from the experimental situation. Behaviour which was not reinforced was slowly omitted from the reservoir of behavioural skills. Also, as behaviour was learned it could be altered and adapted by learning experiences (Skinner, 1953).

Skinner regarded the self as a reservoir of behavioural responses appropriate to a given set of reinforcement contingencies. The traditional behavioural view of the linear model of cause and effect regarded man as an autonomous agent responsible for his own life. The scientific model was that a person was a member of a species shaped by evolutionary biological stimuli for survival, and

the person's behaviour was under the control and influence of the environment in which he lived. The ways in which people perceived and understood their situation was determined by environmental factors (Miller, 1982).

Skinner argued that consciousness or awareness was a social product shaped by the environment. The complex activity called thinking could be explained in terms of reinforcement. Thus the self was a reservoir of behaviours acquired through an environmental history of reinforcement and maintained or extinguished through current contingencies of reinforcement (Skinner, 1973). Skinner maintained that this was a complete theory for explaining human behaviour. It focused upon the individual and did not acknowledge the influence of the social groupings that characterise people's lives.

NEUROTIC BEHAVIOUR

In the development of behavioural psychology anyone who was interested in learning or behaviour modification was inevitably interested in maladaptive behaviour. Maladaptive learning could not be adequately explained by the elementary and survival theories of early behavioural psychology. Wolpe (1958) was concerned to know how people altered behaviour and ceased to react in previous conditioned ways. He was interested in reciprocal inhibition which involved eliciting one response in order to bring about a decrease in the strength of a simultaneous response.

Wolpe experimented with cats and by treating them with electric shocks he created the response of neurotic behaviour in them. Neurotic behaviour was:

'any persistent habit of unadaptive behaviour acquired by learning in a physiologically normal organism.' (Wolpe, 1958, p. 32)

Wolpe maintained that old habits could be eliminated by allowing new habits to develop in the same experimental situation. The term reciprocal inhibition refers to the situations in which the elicitation of one response brought about a reduction in the strength of another response. Since neurotic behaviour was the result of unfortunate learning or a lack of appropriate learning, its elimination must require relearning or additional learning experiences.

'If a response antagonistic to anxiety can be made to occur in the presence of anxiety-evoking stimuli so that it is accompanied by a complete or partial suppression of the anxiety responses, the bond between these stimuli and the anxiety responses will be weakened.' (Wolpe, 1958, p. 332)

BEHAVIOUR MODIFICATION

Eysenck was the first behavioural psychologist who worked in the UK. In 1955 he was appointed professor of psychology at the University of London and for many years edited the journal Behaviour Research and Therapy. He has had a very influential effect on the development of behaviour modification in this country.

Eysenck argued that neurotic behaviour, which he defined as behaviour followed by negative consequences, should be eliminated through the interaction between an

individual's biological reservoir of behaviour and the effects of environmental stimuli. Neither Skinner's law of reinforcement nor Watson's theory could explain the fact that in neurosis elimination did not take place. It was noticed that the emphasis of behavioural psychologists was upon the consequences of behaviour not how it was caused. This was a serious limitation for investigating a chronic illness when antecedent behaviour may have affected both aetiology and pathogenesis.

Eysenck acknowledged that there were four possible sources of neurotic behaviour. First, they may be innate, for example when the degree of fear was strong on first encountering the stimulus. Second, they may be attributed to preparedness when the fear was weak and the conditioning was easy at the first encounter of the stimulus. Preparedness means that certain fears are highly prepared to be learned by humans. Third, neurotic behaviour may be learned through modelling or imitation. Fourth, and the most important source of learning of fear responses, was classical or Pavlovian conditioning.

Eysenck became interested in ways in which neurotic behaviour could be eliminated. He proposed ways in which using a model of social engineering, neurotic behaviour could be modified. Eysenck maintained that behavioural psychology could engineer social consent. He proposed a technology of behaviour which would make people behave in socially accepted ways and would maintain established patterns of social life and its institutions. The token economy methods however could only be applied with patients in custodial institutions. Evaluations of the

effectiveness of this method do not have proven efficacy (Kazdin and Wilson, 1978).

The social engineering model based upon the reward of acceptable behaviour has little to offer people suffering from a chronic illness. There is little evidence to show that rheumatoid arthritic patients are neurotic. It has been shown that rheumatoid arthritis and schizophrenia are mutually exclusive (Rimon, 1985). Similarly there was little to suggest that they adopt deviant behaviour patterns except in the case of Parson's model discussed in Chapter 1, but it will be remembered that this model applied to acute illness more readily than chronic illness.

The social engineering model was a powerful technique and one quickly adapted by a range of disparate interests. Behaviour modification could be applied to any form of human behaviour and therefore could be used by industry, advertising, government, agencies of social order, all of which tended to see behaviour modification as a panacea. Behaviour modification has not lived up to its initial promise. It did not bring about permanent changes in behaviour (Bandura, 1977).

Theoretically behaviour modification can be shown to engineer social consent and maintain the status quo. In so doing it maintains and legitimises a positivistic and mechanistic view of man that serves an ideological function whilst acting under the guise of an objective and value free science (Heather, 1976). Scientific methodology achieves this by negating the senses, feelings and consciousness. It not only alienates man from his innermost self, but in

presenting a view of man and other creatures as mere things, it alienated him from them and made exploitation easier and more inevitable. It was for these reasons that behavioural modification has not been shown to be an effective and permanent form of therapy.

SOCIAL LEARNING THEORY

The behavioural modification theory had been based upon the scientific view of man as a machine. Most of the experiments that had been conducted were designed upon the basis on which the theories had rested. These experiments were conducted in the laboratory and the subjects had been animals. Bandura was to recognise that most learning took place in a social context and he was to argue that the scientific model was unable to account for the sophisticated and subtle behaviour patterns that people enacted.

Bandura attempted to bring together the pure behaviourist with the humanistic psychologists. He maintained that the environment did not completely account for the behaviour of humans, nor did humans entirely determine what the environment was like. Bandura argued that there was a reciprocal interaction between external events and personal determinants such as genetic endowment, acquired competencies, reflective thought and self-initiation. Bandura brought personal determinism into behaviour theory.

The argument that behaviour was something that had developed from experiences that were external to the individual had to be adapted (Bandura, 1977). Personal determinism became to be seen as important. Personal

determinism recognised that it was not necessary for people to learn all their behaviour from the consequences of their interaction with the environment but that they could learn by observing other people's behaviour and assessing its consequences for them. These developments were to be criticised as producing a model which was still too simplified because it failed to incorporate the influence of social groupings (Staddon, 1984).

Bandura maintained that people learnt by direct experience. They learnt the positive and negative results of their actions, they did understand the effects on their responses. Bandura argued it was unnecessary for people to learn all their behaviour from the consequences of their own responses. Most learning took place on a vicarious basis through observation of other people's behaviour. Observational learning or modelling may be used both for the acquisition of new responses and for the inhibition of existing responses (Coombs et al., 1984a).

Social learning theory heavily emphasised the role of expectancy or anticipant as an antecedent determinant of behaviour. The stimulus response model in which people automatically respond to stimuli was wrong, it was argued, since it failed to take into account the fact that people interpret stimuli (Coombs et al., 1984b). Reactions to given stimuli were not the automatic results of conditioning but were largely self activated on the basis of learned expectations.

Self efficacy was a central concept for understanding and analysing changes in behaviour (Bandura,

1977). Self efficacy could be influenced by a mastery expectation and an outcome expectation. The mastery expectation arose when an individual realised that it was possible to perform a certain task. The outcome expectation concerned the confidence that he had the ability and could achieve the required outcome. Some mastery expectations were strong and led individuals to persevere despite not achieving the required outcome, whilst others who have the mastery expectations are not motivated to achieve anything.

PSYCHOLOGY OF BEHAVIOURISM AS THERAPY

Behavioural psychology maintained that much of the behaviour that caused either physical or mental illness was learned and therefore the subject of manipulation. In theory the object of therapy was to discover variables that could be used to alter dysfunctional behaviour. The main tool for the therapist was to be non-punishing and to respond in ways that were incompatible with punishment. Two consequences were possible. First, behaviour which had been repressed may begin to appear in the repertoire. Second, some of the effects of the punishment the client had received may become extinguished or extinct. Both were potentially therapeutic.

Not all dysfunctional behaviours were caused by excessive punishment. For example there may have been the lack of adequate means of individual control in which case the therapist may add new controlling strategies to the repertoire of behaviours or alternatively strengthen responses that were already there.

In overcoming the neurotic reactions of clients it

was important to discover which stimuli actually evoked the abnormal behaviour. In reciprocal inhibition the job of the therapist was to decide which alternative response could be substituted for the neurotic response. The main ones were relaxation, assertive, respiratory, sexual and 'anxiety-relief' response. Relaxation responses which used systematic desensitisation were probably the most common therapeutic intervention.

Behavioural therapy could be capable of being individually designed for each patient and could be capable of being measured or observed (Krumboltz, 1966). Although in no way definitive, the following list includes some of the more typical areas of concern for the group therapist:

- 1) absence of deficits in behavioural repertoires (Demchak et al., 1985);
- 2) absence of weaknesses in behavioural repertoires (Houts et al., 1984);
- 3) absence of debilitating anxiety reactions (Poiletman, 1984);
- 4) capacity to relax (Klein, 1984-85);
- 5) ability to assert oneself (St. Lawrence et al., 1983);
- 6) adequacy at sexual functioning (Leonard and Hayes, 1983);
- 7) capacity for self control (Stitzer et al., 1983);
- 8) capacity for self regulation (Wing, 1985);
- 9) adequacy as a behavioural model (Nelson-Jones, 1982).

The list emphasises mechanistic behaviour patterns

of the individual and tends to ignore the range of social influences which also determines behaviour. The list has little correlation with the psychological concomitants of rheumatoid arthritis discussed in Chapter 2.

BEHAVIOUR THERAPY IN GROUPS

The transition from applying behavioural psychology from individual therapy to group therapy has been made without any significant alterations to theory. In most cases it has been a pragmatic change to assess efficacy. The majority of reported cases consist of direct transfer of individual oriented procedures to a group situation with patients having homogeneous problems like phobic complaints, frigidity and impotence, using techniques such as systematic desensitisation (Lazarus, 1968).

Behaviour modification was essentially a simplified process. It broke down behaviour into small sequences and then tried to alter them. If it was effective it would be easily shown. However behaviour was much more complex and outcome proof of research was much more difficult to find. Behaviour modification's principal technique was self control and included methods of self-monitoring, stimulus control, self-reinforcement and contingency contracting. In many cases the programmes followed were pursued in groups. Obesity provides one example.

Obesity demonstrated the general efficacy of outcome measures in assessing behavioural modification techniques. From a review of the literature five tentative conclusions have been reached:

1) behavioural treatment has proven more effective in producing weight loss than alternative treatment methods in the short term;

2) studies comparing the long term success of behavioural treatment of obesity have been conspicuous by their absence and where data on long term efficacy exist they are discouraging;

3) behavioural treatment programmes have almost always produced weight losses that fall short of clinical significance even if they are statistically significant within individual studies;

4) behavioural treatment programmes have been consistently characterised by massive inter-individual variability in outcome;

5) reliable predictors of treatment outcome have yet to be identified. (Wilson, 1979).

Behaviour modification was most frequently used in cases of sexual dysfunction (Leonard and Hayes, 1983), sexual deviance (Harbet et al., 1973), addictive disorder such as alcoholism (Polivy and Herman, 1976), drugs (Stitzer et al., 1983) and cigarette smoking (Etringer et al., 1984; Hall, 1985), and psychotic disorders (Demchak et al., 1985). Some of the methods of treatment were unsuitable for patients with rheumatoid arthritis. Aversion therapy which can involve the administration of electric shocks cannot be regarded as a suitable form of treatment (Bancroft, 1974). In the case of a physical disease it may have an effect upon the behaviour associated with the disease. It was unlikely to be appropriate for the disease itself.

Behavioural modification programmes conducted in groups are becoming increasingly common in medical settings. They deal with heterogeneous problems such as cardiovascular disease, pain, tension and migraine headaches, sleep disorders, gastrointestinal disorders and others. Specific therapeutic behavioural changes were known for these diseases, so programmes have a predetermined aim. In the case of rheumatoid arthritis cure and treatment have not been established and group programmes have not had predetermined aims (Henckle, 1975; Udelman, 1977; Shwartz et al., 1978; Udelman and Udelman, 1978; Chaplain and Cosign 1981; Shearn and Fireman, 1985; Strauss et al., 1986).

The group therapists can use the group as a resource to help them make an assessment of an individual patient's behaviour. Behavioural psychologists were interested in patterns of learned responses that an individual makes. In this respect the group can act as a resource and offer some potentially therapeutic treatments. Five of the therapeutic treatments the group situation utilises are feedback, relaxation therapy, role play, desensitisation and social reinforcement, however they do not depend upon the group situation in the same way that humanistic psychology depends upon the group environment as will be discussed in the next section. The five therapeutic treatments are investigated in turn.

Feedback Members of the group were encouraged to interact openly with each other. Initially, responses to behaviour were given as feedback expressed in general terms. As the group became more cohesive and open the group

therapist worked towards responses which were given in more concrete terms so the patient could learn how other members perceived him. This kind of approach has been used for drug therapy (Taylor and McKinlay, 1984), smoking (Moss et al., 1984), EMG (Spence, 1984) and chronic joint pain (Funch and Gale, 1984).

Relaxation therapy Patients can be given relaxation therapy in groups. They were encouraged to relax using one of a number of techniques ranging from verbal relaxation, brief muscular relaxation, mental relaxation, differential relaxation, conditioned relaxation and relaxed life style (Nelson-Jones, 1982). The techniques have been used for drug abuse (Hall et al., 1984), tinnitus (Lindberg et al., 1984), childhood disorders (Masek et al., 1984), anxiety (Scott and Clum, 1984) and depression (Klein, 1984-85). It has also been used for patients suffering from severe rheumatoid arthritis with moderate improvement (Burke et al., 1985).

Role Play When a situation arises in the group relating to a patient's difficulties with people outside the group, some form of role play can help. Incidents can be re-enacted and feedback about performances given. This is similar to interpersonal learning which was discussed in the section on psychoanalytical psychology. The patient can practise new behaviours until the patient was satisfied with the way he has handled a situation (Mann and Decker 1984). Interpersonal conflicts occasionally form the source of the problem and assertiveness training can be given (St. Lawrence et al., 1983). Experience of role reversal was sometimes

helpful. The patient adopted the role of his protagonist and begins to understand the protagonist's reactions to his behaviour and how he might deal with him. Fears and anxiety can also be treated by role play (Poiletman, 1984). It was also a useful technique for medical problems such as hypertension (Morrison et al., 1985), or psychiatric problems such as drug abuse (Jordan, 1985).

Desensitisation This refers to the variety of procedures for gradually reducing or eliminating the capacity of a given stimulus to evoke fear, anxiety or guilt. Agoraphobia was an example of a dysfunctional behaviour to which desensitisation can be applied (Ost, et al., 1984; James, 1985). When the patient no longer reacts to the dysfunctional stimulus desensitisation has occurred.

When the goal was the removal of unadaptive emotional responses, experimental counter conditioning and extinction are sought as in cases of obsessive-compulsive behaviours (Foa et al., 1985). Other members of the group can act as powerful role models and also encourage the patient by identifying with his problem. The technique can be used for a wide range of problems including dental fear (Harrison and Carlsson, 1984) and social skills such as public speaking (Krugman, 1985).

Social Reinforcement Group pressure was a powerful motivating force in changing attitudes and behaviour. The group therapist can channel pressure on each member to

achieve some change in behaviour in a therapeutic direction. The patient identifies the inappropriate behaviour and the group specify an improved response (Krohn et al., 1984). The direction of change was kept overt by constantly making reference to the goals to be achieved. The behaviour therapist can interrupt and normally will not hesitate to give appropriate advice that he sees as being potentially effective (Paternoster et al., 1983). The therapist has the advantage that he has been identified as the expert and he has little difficulty in applying cohesive group pressure when he feels it necessary.

Just as group pressure motivates the initiation of new behaviour, group approval of action completed serves as a powerful reinforcer of that action, further increasing the probability that the new behaviour will be repeated and broadened. Once a person begins to conform to group pressure he receives group reinforcement through direct statements of approval (Lorber et al., 1983). The member can be reinforced by being accepted by the group. The added acceptance of pain and sharing of joys increases the cohesion of the group. The feeling of belonging that develops further increases the motivational and reinforcing power of the group. It has been shown to be a useful technique for problems such as drug abuse (Lanza-Kaduce, 1984), smoking (Burr, 1984) and memory loss (Gormly, 1984).

It has been shown that the behaviour therapist has a number of treatments at his disposal. When working in a group situation, the group therapist takes a very active part in directing the activities of the group and in selecting one of the treatments to cure the patient's problem. The

problems always have a behavioural component and treatment is intended to correct this dysfunctional aspect. In the case of rheumatoid arthritis none of the treatments has been shown to cure the disease or ameliorate the dysfunctional behaviours. As yet there are neither psychological or physical cures available to the therapist. To offer any of the above treatments as sources of cures would be clearly unethical. However all of the treatments have something to offer patients and in some cases have been shown to be effective. As research tools to investigate the underlying causes and effects of the disease, they do not offer proven efficacy.

SUMMARY

The developments in the growth of group therapy so far considered have been dependent upon on the principles of psychoanalytic and behavioural psychology. Both have had considerable influence on the development of the social sciences. Unlike psychoanalysis, behavioural psychology has had its initial impact outside the field of psychology, in biology and physiology.

Behavioural psychology perceived a person's entire personality as a complex constellation of specific stimulus-response connections that had been sequentially learned over a long period of development. Because of its foundation in animal learning studies which could be conducted under controlled laboratory conditions, behavioural psychology developed as a part of experimental psychology and its initial thrust was in the area of basic research. Its

emphasis was on man responding stably and differentially to the various stimulus properties of his environment and it was bound to have important implications. The behaviourist maintained that all behaviour was learnt and could therefore be unlearned. Individuals could be reconditioned through a re-ordering of the stimuli to which they had been exposed. Consequently, the emergence of behaviour modification programmes as an alternative approach was one of the most significant developments within the field of clinical psychology during the late fifties and sixties. This sometimes led to optimistic claims being made for behavioural therapy.

'Perhaps one day we shall have ways of making people like things that they do not like, but we do not have them now.' (Wolpe, 1973, p. 178)

Despite the objective approach behavioural psychology was not the optimum theoretical basis upon which to base a therapeutic intervention for patients with rheumatoid arthritis because:

1) behavioural psychology was primarily concerned with the consequences of behaviour and largely ignored the causes of it. It makes little attempt to understand or explain why the behaviour occurred originally. This limitation detracts from its efficacy because in the case of illness, the antecedents of behaviour can be important. It was seen in Chapter 2 that personality factors can play a part in the aetiology and pathogenesis of disease and it would be inadvisable to ignore them.

2) behavioural psychology was not just one theory but it covers a number of competing approaches. It seeks to

accommodate the early work of Pavlov and Watson with that social learning theory of Bandura. Pavlov and Watson have very close theoretical links with biology and physiology, whereas Bandura has close links to humanistic psychology. The connection between them was one of a practical nature rather than a theoretical one and it would be difficult to maintain an argument of commonality amongst the various approaches.

3) behavioural psychology was a successful therapeutic intervention in the short term but its long term effectiveness has yet to be proved. This short term effectiveness would suggest that it was more applicable to acute illness and does not lend itself to long term interventions concerned with chronic illness.

4) the behaviour therapist has at his disposal a range of treatments that he can use to alter and modify behaviour. In the case of rheumatoid arthritic patients behavioural dysfunction has not been clearly identified and to try and apply one of the range of cures is premature.

5) behaviour therapy tends to emphasis the individual person and fails to recognise the importance of social influences which affect behaviour, particularly social groupings.

For these reasons behavioural psychology was not adopted as the main underlying theoretical basis upon which the group counselling could be based. However, some of the techniques, such as relaxation therapy would be used at appropriate times. These techniques were to be incorporated

into an eclectic model of group counselling. It has been noted that behaviour theory tends to ignore the social environment in which behaviour occurs. Humanistic psychology redresses the balance and puts man and his social settings in the centre for its analysis of understanding human behaviour.

Section 3

HUMANISTIC PSYCHOLOGY

Introduction

Humanistic psychology had been referred to as the third wave of psychology (Maslow, 1970) coming chronologically behind psychoanalytical and behavioural theory. Humanism represents a different way of approaching people and of understanding their behaviour. It emphasises different aspects of behaviour motivation.

Humanistic psychology has its origins in humanism which was less of a philosophy and more a set of beliefs which have been particularly influential since the Renaissance and which pre-dates the Cartesian-Newtonian paradigm. The beliefs were based upon phenomenology more so than psychoanalytical or behavioural psychology (Campbell and Cull, 1979). Evidence of the beliefs were found in literature and the arts. Humanism explored behaviour through an examination of people's instincts, motives and drives in different situations. Humanism recognised, portrayed and explored not only the tragic dimension of human existence but also man's ability to transcend the normal boundaries and limitations of human achievement.

Humanistic psychology stressed the importance of an individual's immediate conscious experience in determining reality. That conscious experience was controlled by the actualising tendency. The humanistic psychologists

maintained that the actualising tendency was the single basic human motive where individuals inherently tended to maintain themselves and to strive for enhancement

It was important to understand an individual's perception of reality if his behaviour was to be understood. The actualising tendency tended to serve to maintain and enhance the individual's experiences and potentialities. It encouraged actualisation. The outcome of the growth and elaboration of the individual was the development of the self or self-concept. As the self or self-concept developed the actualising tendency operated to actualise the emerging part of the individual. The tendency was then called self-actualisation. The self-actualising tendency can be considered as a sub-system of the more basic actualising tendency.

This section starts with a historical overview of the development of humanistic psychology commencing with the work of Moreno. It continues by tracing the influence of gestalt psychology and T-groups. It then examines encounter groups and how they may be used in the process of group counselling for patients suffering from rheumatoid arthritis. The section ends with a summary where the conclusion that humanistic psychology is the optimum basis for group counselling is presented.

THE THEORY OF HUMANISTIC PSYCHOLOGY

Humanistic psychology was to be based and developed largely on an influential group of theorists (Moreno, 1940, 1953, 1964, 1966; Allport, 1950, 1955, 1960; Rogers, 1938, 1942, 1951, 1961, 1964, 1969, 1970, 1980,

1985; Maslow, 1962, 1970; Perls, 1976; Lewin, 1963; Schutz, 1967, 1971, 1973, 1975; Egan, 1970, 1976, 1977, 1982). Most of these contributions cluster around the 1960's and 1970's and some were specifically concerned with groups. However, one of the earliest contributions to humanistic psychology as distinct from humanism, dates back to the beginning of the century and the work of Moreno.

Moreno developed psychodrama as a theory of group therapy. Moreno was essentially an actor who became a therapist and made use of Aristotle's proposition that the task of drama was to produce through the exercise of fear and pity a liberation of emotions in people's lives. Moreno believed that such an exercise was an example of therapeutic catharsism.

PSYCHODRAMA

Psychodrama had taken on the properties of a formal model or system by 1921 when Moreno opened his Theatre of Spontaneity in Vienna. The influence of psychodrama on group therapy as a whole has been diffuse and certainly less pronounced than that of psychoanalytic or behavioural psychology. One of the most significant contributions psychodrama made to humanistic psychology was the creation of a specific technique usually referred to as role playing. As was noted in the section on behavioural psychology, role playing was taking on the part of another person and acting out their role.

All approaches to group therapy from Pratt (1917) onward as was noted at the beginning of this chapter, have

assumed that opportunities for mutual support and identification among members were therapeutically beneficial. This assumption was corroborated when Moreno's theoretically systematic framework took into account the specific relationship between the patient and the rest of the group. The process of empathic identification whereby group members gained help from other patients and also gave help, received careful attention from Moreno. The concept of empathic identification was bound to influence the process involved in therapeutic groups. Although psychodrama made the patient's role more formal, all models of group interaction involved one particular member assuming the centre of the action while the remainder of the group focused on them. This method of working was to be adopted by gestalt and encounter groups to begin with but was later to develop to include the group-as-a-whole as will be seen later in this chapter.

In 1927 Moreno emigrated to the USA where he was to spend the rest of his life involved in the development of humanistic psychology and group therapies. In 1936 he founded the Therapeutic Theatre and experimented with role play. Moreno originated the concept of role play and acting out. It is one of the few therapeutic concepts that psychoanalytical and behavioural psychologists have borrowed. Psychoanalytical and behavioural psychologists did not actively dramatise the emotional struggles of their patients. They were more voyeuristic than exhibitionistic, whereas the reverse may well be true of Moreno and psychodrama (1966).

In psychodrama the patient could derive a certain

satisfaction from acting out, rather than just talking about, his emotional conflicts depending upon his personality. Moreno maintained that acting out was a greater therapeutic experience and the outpouring of emotion provided a cathartic experience from which the patient benefited. Moreno had developed his idea from psychoanalytical theory, but psychoanalysts would not have agreed. They would have considered it an example of resistance because catharsis has a tendency to interfere with the patient gaining insight into his problem, in which case the release of emotion could be the patient's only benefit.

The dramatic acting out through psychodrama allowed the patient to relive actual situations which were the source of their emotional problems. Through acting out the patient could also assume the part of another person and gain a new insight into the emotional conflict. It also gave the patient the opportunity to try out new types of behaviour.

Moreno was an influential theorist in the academic disciplines of both psychology and sociology. His work is reflected in many developments and he claimed to have pioneered the development of the encounter group, gestalt therapy, transactional analysis and behaviour therapy. Psychodrama forms a chronological introduction to humanistic psychology (Moreno, 1940, 1964).

GESTALT PSYCHOLOGY

Gestalt psychology had a stronger theoretical base than psychodrama. It developed from the ideas of gestalt

psychologists (Kohler, 1925, 1930; Wertheimer, 1938, 1959). Their theoretical ideas created an influential base from which gestalt group therapy was formulated (Perls, 1976). Gestalt therapy was directed towards creating changes in a patient's awareness of situations and circumstances so that they could adopt different approaches to life events. Gestalt methods were designed to increase awareness and encourage self- disclosure.

Gestalt therapists had a number of techniques for concentrating a patient's attention on the complete environment in which he was operating. One such technique was skilful frustration, where the therapist tried to discover what issues the patient avoided, or the way in which they failed to make satisfactory contact with other people. The therapist frustrated the patient to the point of exasperation. When the patient was exasperated sufficiently they would then be prepared to confront their own inhibitions and analyse the dysfunctional aspects of their behaviour.

Through interaction with the therapist the patient would begin to appreciate the ways in which they had understood and accepted only part of the environmental information available to them. They would also become aware that they had been avoiding issues and not making open contact with other people. Gestalt therapy focused upon present behaviour and concentrated upon concerns of the moment. It made no attempt to investigate the antecedent causes of present problems or to project to the future. Gestalt therapy was one of the important strands in the development of group counselling although it was also to

remain a theory in its own right. One of the other important strands was to come from the theories of Lewins and T-groups.

T-GROUPS

The two earliest groups were the Tavistock and the T-group. They differ in national and philosophical backgrounds, Tavistock having originated in the U.K. within a psychoanalytic framework and the T-group in the U.S.A. within the scope of the behavioural science theory. Both developed from the theoretical framework of Lewins and have much in common. They were both directed toward helping people to become more knowledgeable about group dynamics and learning about group processes. They did not cater for people with dysfunctional behaviour. Both saw the group's task as that of studying its own behaviour. They tried to keep the group as unstructured as possible by the elimination of hierarchies, fixed agendas and democratic procedures. These were features of organised groups that tended to avoid interpersonal tensions and conflicts. The Tavistock group has been discussed in the section on psychoanalytical psychology and comments will be confined to T-groups.

The idea for the T-group model grew out of a conference in 1946 for business and community leaders in the USA. At this conference task groups composed of these leaders were formed for the purpose of discussing the improvement of interpersonal relations and the use of groups in developing closer relations among communities. Four years

later the National Training Laboratory was formed as a centre for training leaders in human relations and group dynamics. The idea was that group participants coming from a variety of backgrounds, could experience and study groups whilst participating in them.

Members began to analyse their own behaviour and the dual purpose of participating in a group at the same time as studying their own behaviour in it became the main aim. Group members were better able to understand both group processes in general and their own individual style in particular in a group. Such groups brought into operation the processes of participation and observation.

The task of the group was to learn and understand from its own behaviour. No other task was given to the group and it had to decide how best to proceed. The group leader would make no attempt to lead the group but would make comments that would help the group to learn from its experiences. As a result the members would gain an increased understanding of the processes that can impede a group's performance and of their own unwitting contribution to that impediment.

The T-group was concerned with group processes and with encouraging a group to become aware of its own dynamics as a group. However unlike the Tavistock model the T-group also attended to how individual participants differentiated themselves from one another in terms of particular roles taken within the group structure. For example, some members were quick to emerge as leaders whereas others seemed destined to play the role of followers. The T-group saw these personality differences as important and they were

used as topics for group discussion and according to this model these personality differences constituted important data that were to be looked at and talked about by the group.

It was Lewin (1963) who made the study of small groups processes academically acceptable and through his emphasis on 'action research' had encouraged researchers to become actively involved in the social situations they were trying to study. The introduction of participant observation as a means of conducting research allowed psychologists and social scientists the opportunity of investigating human behaviour outside laboratory conditions, where they were not confined by the rigid limitations of the scientific research methodology (Sullivan, 1953).

The T-group was the precursor of the encounter group. Some of the people who were trained as T-group leaders were to move from the focus of 'group relations and organisational emphasis' to a group with a 'personal-interpersonal focus'. Rogers (1967) had become interested in using groups as a vehicle for training students in counselling procedures as early as 1946. Rogers developed groups that resembled T-groups in that they did not need therapists to run them and were suitable for healthy people.

The intensive group experience was directed more toward helping a person find genuine authenticity in his manner of relating to others and to himself than it was toward helping him to develop either 'interpersonal skill' or an increased understanding of group dynamics. This

increasingly personalised focus was to take over and little attempt was made to teach the participants about group dynamics or to help them relate their group experience to their outside work situation. Instead through direct confrontation and through a variety of specific techniques including psychodrama, gestalt therapy exercises and guided fantasy they would be encouraged to encounter the 'true' feeling self that lay beneath their social and professional facades.

A decade later the emphasis had changed in the National Training Laboratory from group dynamics to personal dynamics reflecting the rise in interest in humanistic psychology. The aim had changed from making groups more effective to making people more effective. The goal of T-groups now became greater self awareness and personal growth. Before long the T-group had given rise to the encounter group movement. However, before the encounter group movement is discussed more concrete determinants of the humanistic psychology concept will be investigated.

HUMANISTIC PSYCHOLOGY

During the 1950's the physical sciences were viewed with increasing suspicion and its objective methods, which ignored human experience, were challenged. During the 1960's protest against the scientific methodology started, particularly amongst the young. The rejection of science and scientific culture represented perhaps the most significant and widespread social and intellectual revolution during this period (Tart, 1975). Theorists in humanistic psychology were to stress three aspects of human experience:

- 1) psychology should be concerned with a person's subjective experiences because the essence of personhood is subjective;
- 2) psychology should study people in their everyday life situations;
- 3) recognition that each person constructed their own model of the external world (Greenway, 1982).

During this period a certain change was noticeable within scientific circles as it became increasingly recognised that concern was being expressed about the dissatisfaction and disillusionment with scientific objectivity. Disappointed with the limited knowledge of the universe revealed by science, man increasingly turned towards himself. Even if humanism was not a definite philosophy it was to receive philosophical support from a number of scientific sources

'If we survey the leading figures of science over this century - for example Bridman (1959), Bronowski (1958), Conant (1952), Eddington (1958), Einstein (1934), Oppenheimer (1956), Schrodinger (1957) and Whitehead (1958) - we find much more support for a humanistic theory of behaviour than for a mechanistic account. A liberal approach to scientific theorising is more current and appropriate than is the staid and lifeless form of Newtonian science that is still dreamed of in too many psychology departments.' (Rychlak, 1977, p. 193)

These developments facilitated the acceptance and development of humanistic psychology (Garai, 1979). Humanistic psychology in some ways progressed out of dissatisfaction with behavioural and psychoanalytic psychology (Gladding and Younce, 1986). Behaviourism had not lived up to its early promise and there was a rearguard action against the notion that behaviour could be controlled in a rigid scientific way. In addition there was rejection about what it implicitly said about man. Behaviourism could not accommodate the essential elements of humanism (Alam, 1983; Gare and Smith, 1984; O'Hara, 1985; Walsh and Peterson, 1985). Humanism argued that man should not be the subject of scientific experiment and therefore could not be investigated or accounted for by behaviourism (McMullen, 1982).

During the 1950's the nature and understanding of groups underwent a marked change as it became recognised that participation in T-group or sensitivity training often led to powerful personal experiences. Dramatic and startling confessions were made, self-disclosure was frequent, and a heightened sense of well-being and personal change took place. Subsequently a plethora of group therapies emerged each offering different techniques for the promotion of self development, growth, and personal fulfilment, and by the 1960's they had become well established.

During the 1960's a number of therapies emerged which focused attention on subjective experience, personal responsibility and meaning. However, in their return to what might be regarded as spiritual human concerns

they were reflecting currents within Western culture as a whole, and most notably the consciousness movement or counter culture, rather than any explicit opposition to positivistic, deterministic psychology as such. What these therapies shared in common, apart from their origins in the counterculture and similar philosophical and ideological underpinnings, is that most of them involved some planned intensive group experience. Whereas, previously, psychotherapy had been considered to be essentially a one-to-one interaction between a therapist and client, emphasis now rested on a group of persons and one or more leaders.' (Graham, 1986, p. 49)

The influence of humanistic psychology changed the focus of interest to that of man himself. This approach rejected both the conditioning emphasis of behaviourism and the deterministic attitude of psychoanalysis and instead developed an existential thrust emphasising man's freedom and self actualising potential (Goldfried, 1982; Smith, 1982) although the benefit of self actualisation is not universally accepted (Geller, 1984). People became concerned that they were using and maximising their potential for happiness. It was probably inevitable that the T-group experience would increasingly be used as a means of self expression and of self discovery that went beyond the issue of work satisfaction to whether people wanted to work at all.

'Man does not simply have the characteristics of a machine; he is not simply a being in the grip of unconscious motives; he is a person in the process of creating himself, a person who creates meaning in life, a person who embodies a dimension of subjective freedom. He is a figure who, though he may be alone in a vastly complex universe, and though he may be part of that universe and destiny, is also able to live dimensions of his life which are not fully or adequately contained in a description of his conditioning or his unconscious.'

(Rogers, 1964, p. 129)

Concurrent with these developments there was in society at large a surging of forces towards freedom and liberation characteristic of the mood of the sixties. There was an interest in mysticism, particularly in the U.S.A. that challenged the traditional values of Western societies. A counter culture evolved that rejected the rational bureaucratic values and roles, promoting instead an expansion of consciousness through a variety of means including meditation and drugs. By the early 1960's Rogers (1967) was referring to the intensive group experience that he lead as the basic encounter group whilst Schutz (1971) was developing his 'open encounter' group at Esalen Institute.

ENCOUNTER GROUPS

Psychotherapy had traditionally operated on a one-to-one basis within a medical setting where the implications

of social undesirability and mental illness was readily apparent. Encounter groups were to be divorced from moral or social stigma. They held the promise of self discovery and the development of personal potential which was latent within people (Lakin et al., 1981). The prospect of encounter groups and their philosophy exerted a strong emotional appeal for many people. They were a means of developing close and intimate interpersonal relationships of a kind often denied in the modern world.

Maslow (1962, 1970) and Rogers (1951, 1961, 1964, 1969, 1970, 1980, 1985), were the two most influential figures who structured the philosophical base upon which the encounter group was to flourish. Maslow argued that man's inner nature could and should be studied objectively through the application of methods taken from science, also subjectively by way of psychotherapy. Maslow maintained that psychology should not be seen a reductionist and deterministic science. He was particularly opposed to the generalisation of findings derived from studies of the mentally ill to the general population.

Maslow argued that psychology should be concerned with the study of mental health in all its aspects. He based his writings upon the optimistic belief that man's nature was intrinsically good and that it was a biological feature of being human as well as a characteristic people developed. He conceived of man's inner nature or self as possessing a dynamic for growth and self determinism. He recognised that some people were weak rather than strong and could be easily frustrated. When individuals were denied and suppressed

their emotions it could give rise to sickness and neurosis. This denial and suppression could be a factor associated with rheumatoid arthritis.

Maslow's philosophical thinking lead him to believe that humanistic psychology was a fundamental change of revolutionary proportion.

'I have come to think of this humanist trend in psychology as a revolution in the truest, oldest sense of the word, the sense in which Galileo, Darwin, Einstein, Freud and Marx made revolution i.e.; new ways of perceiving and thinking, new images of man and of society, new conceptions of ethics and values, new directions in which to move. The third psychology is now one facet of a general Weltanschauung, a new philosophy of life.' (Maslow, 1968, p. iii)

Rogers, like Maslow, argued for the inherent goodness of man and his philosophical writings are voluminous. His optimistic views are a characteristic of his writings and illustrate the basic beliefs of humanistic psychology and are worth quoting at length.

'The individual has within him the capacity and tendency, latent if not evident, to move forward to maturity. In a suitable psychological climate this tendency is realised, and becomes actual rather than potential. It is evident in the capacity of the individual to understand those aspects of his life and of himself which are causing him pain or dissatisfaction, an understanding which probes beneath his conscious knowledge of himself because of their threatening nature. It shows itself in the tendency to

reorganise his personality and his relationship to life in ways which are regarded as more mature. Whether one calls it a growth tendency, a drive towards self actualisation, or a forward moving directional tendency, it is the mainspring of life, and is, in the last analysis, the tendency upon which all psychotherapy depends.' (Rogers, 1961, p. 35)

The encounter group, unlike its predecessor the T-group, did not take pains to make a careful distinction between its purposes and those of therapy groups. Encounter groups avoided comparisons with the medical model of disease and treatment. The application of encounter groups to medical settings would represent a new initiative. Instead they argued that twentieth century man was in desperate need of renewed contact with himself. Encounter groups cannot be divorced from earlier therapy models and were a logical extension of the innovations in group techniques that preceded it.

The extension of the earlier therapy groups led to a number of developments. The leader was at greater liberty to express personal opinions and members could dramatise their problems as well as verbalise them. Group therapy methods were defined as applicable to normal people. Therapists became more aware of non-verbal communication and when the non-verbal and verbal messages were not congruent, the non-verbal message was given precedence. A humanistically oriented counter culture began to question traditional values, organisations and methods including the need for fixed roles and clear cut goals and procedures. The

liberal atmosphere and loose structure of the encounter group facilitated this change (Schutz, 1975; Yalom, 1975).

Rogers argued that therapy was a process where the individual had the opportunity to reorganise his subjective world and to integrate and actualise the self-concept leading to increased self satisfaction, self reliance, inner direction and decreased inhibition (Bebout, 1971/72). He viewed the central process of therapy as a facilitation of the individual's experience of becoming more autonomous, spontaneous and a more confident person. This form of therapy is apposite for patients suffering from rheumatoid arthritis together with other chronic illnesses as they have to cope with a threat to self-image identified in Chapter 2 and conceptualised by the concept of spoiled identity (Goffman, 1959).

Rogers maintained that this form of therapy depended upon the counsellor bringing three basic qualities to the therapeutic relationship. The first quality was the authenticity or genuineness of the therapist. For this to be achieved the therapist must be aware of his own feelings, in so far as that was possible. He must be able to express his own attitudes or feelings if appropriate. The second quality of the therapeutic relationship was that the therapist had positive unconditional regard for the client. The therapist respected and valued the client as an individual irrespective of his problems, feelings or behaviour. The third quality was empathic understanding or genuine listening which entailed a continued ability to understand the feelings and personal meanings which the person was experiencing.

Rogers argued that within such a relationship there was an implicit freedom from moral or diagnostic evaluation which he believed was always threatening. The diagnostic evaluation would appear to be a concomitant of rheumatoid arthritis, as was discussed in Chapter 2. Rogers claimed that within such conditions the person:

- 1) moved from a fear of introspection and defensiveness to an encouragement of insight and openness;
- 2) from being out of touch with their inner feelings to an acceptance and awareness of them;
- 3) from living by the values of others to those experienced by the person;
- 4) from distrust of the spontaneous aspects of themselves to trust in those aspects;
- 5) towards greater freedom and more responsible choice.

This list of factors would appear to coincide with the therapeutic needs of patients trying to cope with the anxiety, hostility, stress, frustration and confusion consequent upon suffering from rheumatoid arthritis.

Whilst these developments were occurring in the field of humanistic psychology changes were being made in the therapeutic approach of psychoanalysis. Upon examination it will be apparent that many of the developments were similar and therapeutic movement in both therapeutic approaches were underpinned by the same concepts. For example, self-disclosure was recognised as an important factor in each approach.

Psychoanalysis had provided the theory upon which psychotherapy was based. Some psychoanalysts found the theory unsatisfactory as it did not adequately account for interpersonal relationships, particularly those of therapist and client. The theory of psychoanalysis was to develop into a humanistic model for therapy through the work of the existentialists (Pervin, 1960; May, 1961, 1974; Szasz, 1979; Laing, 1983). The existential model was psychoanalytic in its basic concept. It accepted unconscious motivation as the fundamental influence upon human behaviour. Its approach incorporated a strongly humanistic dimension that emphasised ontological concepts involving the patient's awareness of himself and his psychological experiences. Whilst it acknowledged there were unconscious motives for what a patient said, it rejected a simplistic reductionist view, where a person's conscious experience was explored for evidence of invisible and unfathomable forces. The readiness to interpret and analyse a patient's inner life led to the criticism that it tended to make the therapist a greater expert on what the patient was really experiencing than the patient himself. This process tends to reduce the patient to the status of an object. This criticism can be traced back to Freud's original description of the unconscious.

'Freud seems to be postulating a metaphysical entity, by definition inaccessible even to the subject to whom it belongs, and then to be claiming to be able to collect information about it.' (Cupitt, 1985, p. 78)

Humanistic psychology maintained that any

investigation of the unconscious had to have as its starting point a deep permanent interest in and respect for the patient's view of himself. This was one of the first principles of humanistic psychology which was strongly phenomenological. The blank screen approach of the Freudian's had not succeeded in hiding the fact that everything the therapist did or did not do revealed his personality to the patient. The humanistic psychologists rejected the blank screen argument. Instead they maintained that the essential quality of being human in the most fundamental sense was the crucial therapeutic component and not the specific techniques that a therapist practised. This therapeutic component could be explored in group counselling. The development helped the therapist to respond in a spontaneous and intuitive way to patients. The relationship was characterised by more normal emotions and the therapist could even admit his irritation with the patient, particularly if the patient was resisting or avoiding some memories or experiences that were blocking progress. This approach helped to guard against the phenomenon of learned helplessness in groups because it protected against dysfunctional learning (Simkin et al., 1983).

The less formalised interaction between patient and therapist led to a process of negotiation and compromise which was also practised in the group therapy situation. The application of humanistic psychology had moved from the individual therapy to group therapy without the need for any fundamental revision. This allowed the therapist to take a role as an ordinary group member on

occasions and disclose some of his personal concerns, insights and problems. Self-disclosure is an important aspect of group work and the degree in which it takes place determines therapeutic movement (Morran, 1982). The therapist's self disclosure would allow the individual members to become more confident about the expression of their intimate feelings (Lakin et al., 1983/84). The individual members also had the opportunity to respond to the therapist's comments about him.

'A facilitator can develop in a group which meets intensively, a psychological climate of safety in which freedom of expression and reduction of defensiveness gradually occur. In such a psychological climate many of the immediate feeling reaction of each member towards other, and of each member towards himself, tend to be expressed. A climate of mutual trust develops out of this mutual freedom to express real feelings, positive and negative. Each member moves towards greater acceptance of his total being - emotional, intellectual and physical - as it is, including its potential.' (Rogers, 1970, p.14)

It is evident that the humanistic psychologists had rejected the disease model of mental illness. They were opposed to the exclusively physiological or genetic explanations of schizophrenia (May, 1974; Laing, 1983) and rejected the mental health profession's obsession with pathology (Taylor, 1984). In common with Szasz (1972, 1973), they viewed such explanations as metaphors for dealing with people whose behaviour and experience failed to conform to the dominant moral and social reality. They also viewed with

disfavour the medical and psychiatric treatment of those metaphorical diseases which ignored the social context of the individual patient and argued that the healthy person was one integrated in mind and body (Vaughan, 1985).

Humanistic psychologists saw that in the group therapy situation communication was primarily verbal and spontaneous but they also recognised the increasing importance of including non-verbal communication. The therapist adopted a non-directive leadership role and patients were free to discuss and disclose their here-and-now problems. This non-directive approach was appropriate to patients suffering from rheumatoid arthritis because it made no presumptions about the causes of the patient's problems. It also gave the group freedom to explore whatever issues they considered to be of importance at any particular time.

'Health is not just an individual affair.

Like disease, it can be spread. Efforts toward health care, therefore, transcend the actions of single individuals. What one person does to improve - or diminish - his health has vital consequences to all other persons.' (Dossey, 1983, p. 143)

The group social context is recognised to be of importance and this focus provides the potential for therapeutic movement.

It was noticed that one of the main differences in approach between psychoanalytical and behavioural methods and humanist methods related to fairly subtle aspects of the

therapist's basic attitude toward the patient (Friedman, 1982; Goldfried, 1982). The difference in approach led to more freedom on the part of both the therapist and the patient and therefore became an important factor which recommended the approach to patients with rheumatoid arthritis because they were approached as people rather than patients. The freedom to explore any issue that the patient considered relevant prevented restrictive theoretical dimensions being place upon the relationship.

Much of the theoretical work that established humanistic psychology as a therapeutic intervention can be dated to the 1950's and 1960's. It would be reasonable to predict that thirty years later some fundamental questions would be raised about the validity and reliability of the theoretical reasoning behind the philosophy. This does not appear to have happened. In fact humanistic psychology has gained support from perhaps a surprising source - changes in scientific thinking. As far back as 1932 the famous physicist James Jean observed,

'Today there is a wide measure of agreement, which on the physical side of science approaches almost to unanimity, that the stream of knowledge is heading toward a non-mechanical reality; the universe begins to look more like a great thought than like a great machine.' (Jean. 1932, p. 16)

It was noted at the beginning of this section that humanism pre-dated Cartesian-Newtonian science. It would seem that humanism may become the more enduring of the two. Cartesian-Newtonian science was now unable to provide scientist with adequate answers. The answers to problems

were now being found in the area of quantum theory which was leading to fundamental changes in scientific thought.

Einstein's theories have resulted in a radical review of Cartesian-Newtonian science. The understanding of the universe has changed from a mechanistic, deterministic paradigm to a relativistic, uncertain one. Conceptual changes at this level have meant that matter does not exist with certainty at definite places nor does atomic events occur with certainty at definite times or in definite ways. One of the consequences of these changes was that if matter does not exist with certainty then there was no possible way of measuring it with precision.

'In modern physics the universe is experienced as a dynamic, inseparable whole which always includes the observer in an essential way. In this experience the traditional concepts of space and time, of isolated objects, and of cause and effect lose their meaning. (Capra, 1975, P. 81)

These developments have resulted in much uncertainty and the traditional basis of science has changed. The changes have been particularly evident in the research designs. Subatomic physics establishes that there was no way of measuring something without changing it. The universe does not exist independently of the observer who measures it.

'Just as there is no organism without an environment there is no environment without an organism. Neither organism nor environment is a closed system; each is open to the other. There is a variety of ways in which

the organism is the determinant of its own milieu.'

(Rose, 1984, p. 273)

The scientific research method depended upon the observations of an independent assessor. Quantum theory established that it was no longer possible, therefore research needed no longer to be confined to the laboratory. This allowed counselling research to be conducted in a more social context. Quantum theory also removed the certainty that it was possible to describe two events as being causally related (Heutzer, 1984). One effect of these changes has been to bring science and mysticism into a closer relationship. Some physicists believe that they are near a single law which underlies all phenomena of nature (Burge, 1985). By the middle of this century physicists had begun to note close parallels between their own evolving image of the world and that taught by the mystics from the East. Zukav, who holds the chair in physics at Berkeley wrote:

'Reality is what we take to be true. What we take to be true is what we believe. What we believe is based upon our perceptions. What we perceive depends upon what we look for. What we look for depends upon what we think. What we think depends upon what we perceive. What we perceive determines what we believe. What we believe determines what we take to be true. What we take to be true is our reality. (Zukav, 1979, p. 328)

These scientific changes has resulted in humanistic psychology gaining a wider acceptance. The

quantum paradigm was characterised by two dynamic and principle phenomena:

'Self-renewal - The ability of living systems continuously to renew and recycle their components while maintaining the integrity of overall structure.
Self-transcendence - The ability to reach out creatively beyond physical and mental boundaries in processes of learning, development and evolution.
(Capra, 1982, p. 269).

It has been argued that these principles of quantum theory were already accommodated in counselling based upon humanistic psychology (Bozarth, 1985).

'Individuals have within themselves vast resources for self-understanding and for altering their self-concepts, basic attitudes, and self-directed behaviour; these resources can be tapped if a climate of facilitative psychological attitudes can be provided.' (Rogers, 1980, p. 115)

It was evident that any psychology which was going to be relevant to contemporary science had to include the domain of consciousness. The problem for psychology, which had been operating within a framework of a materialistic, deterministic and mechanistic paradigm had been coping with consciousness was now solved. The influence of quantum theory shows that the branch of psychology that best incorporates consciousness is humanistic psychology (Rogers, 1985).

SUMMARY AND CONCLUSIONS

It has been argued that psychoanalytic and behavioural groups were different from humanistic groups. Psychoanalytical and behavioural groups were specifically designed for the rehabilitation of patients suffering from specific psychological or psychiatric symptoms and not for patients with the symptoms of rheumatoid arthritis. Humanistic groups were designed for people who were psychologically normal and were looking for experiences that would enhance their personal living, particularly as it related to interpersonal relationships. As there was no evidence that patients suffering from rheumatoid arthritis were psychologically abnormal this approach would appear to provide a more facilitative therapeutic intervention.

The recent developments in medicine have been away from the disease model in which the body and mind were viewed as separate however, this movement is small and cautious. Many medical professionals still regard the body as a machine and the mind as a secondary factor in organic illness. There has also been the beginnings of a movement away from the treatment of individual symptoms by objective, emotionally uninvolved, authoritarian practitioners with drugs and surgery, towards a holistic perspective in which the mind and body are seen as part of the same integrated person. These changes have resulted in treatment being of minimal technology. In addition emphasis has been placed upon the autonomy and responsibility of the person in the healing process. This change has been best accounted for by developments that are based upon quantum theory and these

developments are reflected in the progress made in group counselling based upon humanistic psychology.

Humanistic psychology argues that the four core conditions of the counselling relationship give optimum chance of group counselling working as a therapy. It allows patients to explore their own lives in any way they wish. The core conditions give patients the opportunity for self-renewal and self-transcendence. These core conditions are not a feature of either the psychoanalytic or behavioural approaches.

The present century has witnessed significant changes in scientific theorising which represent a paradigm shift. Whilst quantum theory has its critics it cannot be ignored and it does provide a serious attempt to answer questions that the Cartesian-Newtonian paradigm cannot solve. Psychoanalytic and behavioural psychology are firmly embedded in the traditional scientific model and only humanistic psychology provides a satisfactory base. For these reasons the groups' counselling will be based upon humanistic psychology.

CHAPTER 4

THE THEORIES OF RESEARCH METHODOLOGIES

INTRODUCTION

This chapter describes the process of selecting a research design. It argues that because the group counselling intervention was to be based upon humanistic psychology a new paradigm research methodology would be appropriate. A new paradigm research methodology would allow the phenomenological aspects of patients' experiences to be explored and it was evident from Chapter 1 that patients' response to a poorly defined concept would be essentially individual. This assertion is supported by the evidence presented in Chapter 2.

One of the weaknesses of new paradigm research methodology was its emphasis on subjectivity and a method of overcoming this limitation was sought. There were a number of standardised objective measures that were available and the weakness was compensated for by including a scientific research methodology which would strengthen the objectivity of the results. The results could then be generalised to the population. In addition, it would then be possible to make an evaluation as to whether the group counselling made any difference to the patient's physical condition. The research design therefore incorporates elements of both new paradigm and scientific methodology and they are discussed.

NEW PARADIGM RESEARCH METHODOLOGY

The term new paradigm is both confusing and

misleading. What it purports to mean does not represent a new paradigm. It is a generic term that includes many different approaches to research. New paradigm research can best be described as an alternative methodology to the traditional scientific approach. The need for an alternative approach arose because many of the important questions that concerned social scientists could not be investigated by traditional scientific methods.

The traditional scientific research methodology was based upon the Cartesian-Newtonian paradigm which was defined and discussed in Chapter 1. The paradigm generated certain theories which were generally accepted as providing a satisfactory foundation for the physical sciences (Kuhn, 1962). Humanistic psychology and quantum theory has shown that there are doubts about the validity of such theories and the need for alternative explanations has arisen. These alternative explanations have included non-scientific subjects. Research using new paradigm methodologies has been carried out in a variety of different academic disciplines. Obviously the field is vast and includes:

- psychology (Allport, 1962);
- anthropology (Beattie, 1964);
- education (Simon, 1980);
- sociology (Glaser and Strauss, 1967);
- philosophy (Harre, 1986);
- medicine (Capra, 1982).

New paradigm research has been conducted under a number of different research methods including: case study, illuminative evaluation, participatory observation,

ethnography, action research, heuristic research, grounded theory and democratic evaluation to name some. These different headings represent alternative thrusts and focuses of interest.

The field is new, exploring and following many diverse hypotheses. As yet it is premature to call the approach anything other than alternative and certainly not a new paradigm. The approaches are based upon philosophies other than logical positivism. Some of the approaches are: praxis, hermeneutics, existentialism, pragmatism, process philosophies and phenomenology (Susman and Evered, 1978). They have yet to be welded into one unifying theory which would be a new paradigm. At present the position could only be regarded as the second stage of establishing a new paradigm according to Kuhn's taxonomy. (Kuhn, 1962).

The non-scientific approaches do have certain unifying features that in time may become the foundations for a new paradigm, but at present are not proven. The unifying features are:

1) there is no absolute or ultimate truth -

'There is no one royal road to truth in social sciences ... all methods have their strengths and weaknesses and all are, in varying degrees messy and unsatisfactory because life is messy and unsatisfactory.' (Coffield et al., 1980, p. 16);

2) clinical phenomena are elusive and reactive -

'When you try to quantify non-verbal behaviour, the essence of its meaning is often destroyed. Further, it may not be the behaviour itself

that is of importance, but the subjective reaction to the behaviour.' (Hill and Gronsky, 1984, p. 155);

3) clinical problems are often intractable -

'Many of the issues we deal with are not solvable or understandable and that we expect too much of research in resolving what may be intractable problems.' (Hill and Gronsky, 1984, p. 155);

4) human behaviour should be studied in a holistic context -

'A practical consequence of recent studies of mind and consciousness is the insistence that the human person must be viewed as an integrative whole involving interdependent physical, psychological, social and cultural patterns.' (Lucas, 1985, p. 170);

5) cause and effect relationships or linear causality are not necessarily implicit in human behaviour -

'There is an old joke about the man who drank too much on four different occasions, respectively, of scotch and soda, bourbon and soda, rum and soda and wine and soda. Because he suffered painful effects on all occasions, he ascribed, with scientific logic, the common effect to the common cause: "I'll never touch soda again!" (Kish, 1959, p. 333)

6) researchers bring their own set of values to the

research context -

'Research can never be neutral. It is always supporting or questioning social forces, both by its content and its method. It has effects or side-effects, and these benefit or harm people.' (Reason and Rowan, 1982, p. 489);

7) the roles of researcher and researched are not independent of each other -

'The new paradigm provides many specific research models, which have differences between them; the factor which unites them is a much closer relationship between the researcher and the researched than is unusual in the experimental method.' (Brandes, 1985, p. 23)

These characteristics reflect quite closely the beliefs implicit in humanistic psychology and would allow the complexities of patient's behaviour to be focused upon. One of the major differences is that the new methodologies have escaped from the rigid and formalised laboratory settings of scientific research methodology. They allow for people to be recognised for research purposes as if they were human beings (Harre and Secord, 1972)

It is difficult to separate many of the approaches and some do not represent fundamentally different methodologies. In arriving at a facilitative research design an eclectic approach was adopted. This approach facilitated the ideas of quantum theory that the researcher always influences the subject of the research and that there was not always a cause and effect relationship to account for all behaviour. This is appropriate for research that

investigates group counselling. Also that self-renewal and self-transcendence are aspects of scientific reality that do translate into health care:

'The basic aim of therapy will be to restore the patient's balance, and since the underlying model of health acknowledges the organism's innate tendency to heal itself, the therapist will try to intrude only minimally and keep the treatments as mild as possible. The healing will always be done by the mind/body system itself; the therapist will merely reduce the excessive stress, strengthen the body, encourage the patient to develop self-confidence and a positive mental attitude, and generally create the environment most conducive to the healing.' (Capra, 1985, p. 154)

A research design based upon the new paradigm methodology would be suitable but given the medical arena in which the research was to be conducted other considerations were taken into account. These were:

1) the results had to have validity in the medical arena. There was little point in conducting the research if the results were to be ignored;

2) a number of standardised measures were available which would increase the validity and reliability of the conclusions and these could be easily used;

3) the medical personnel who collaborated in the research would not have satisfied if a proven design had not been followed and of necessity this meant a scientific design;

4) one of the weaknesses of new paradigm research is its emphasis upon ideographic research. A nomothetic approach would permit the results to be generalised to the population (Windelband, 1894);

5) although the researcher was unaware of the fact at the time, the approval of the local ethical committee was to be necessary and the inclusion of a scientific research design facilitated their agreement. An account of this incident is given in Chapter 5.

Therefore the research design would be improved by the incorporation of the scientific research methodology. This methodology is based upon fundamentally different concepts from those in new paradigm research and are now discussed.

SCIENTIFIC RESEARCH METHODOLOGY

The foundation on which scientific research methodology rests can be dated back to the beginning of western civilisation. The foundation was laid in the first mathematical principles by Plato and Socrates (Plato, 1956). The mathematical foundation of scientific research methodology has influenced much of its subsequent development. This development can be traced through the work of, amongst others, Descartes, Newton, Kepler, Copernicus, Galileo and Mill all of whom helped to determine the system of logic that came to be accepted as the base for scientific research. This system sought to reduce complicated problems and questions into small manageable steps. The logic of the system was convincing and was meticulously and persuasively formulated in a set of Rules by Descartes. The Rules were

essentially simplistic and reductionist which can be illustrated by Rule 5:

'Method consists entirely in the order and disposition of the objects towards which our mental vision must be directed if we would find out any truth. We shall comply with it exactly if we reduce involved and obscure propositions step by step to those that are simpler, and then starting with the intuitive apprehension of all those that are absolutely simple, attempt to ascend to the knowledge of all others by precisely similar steps. (Descartes, 1969, p. 50)

The reduction of problems and questions to simple steps allowed scientific research to flourish. The process was accepted as the method of verifying facts and the establishment of knowledge. The logic of the scientific approach was to find support in the arguments of Comte and Mill who developed the philosophical school of logical positivism. This school maintained that logical positivism entailed methodological monism which was the idea of the unity of scientific method despite the diverse range of subject matter investigated by it. Monism was based upon the view that the exact natural sciences, in particular mathematical physics, set a methodological standard against which all other sciences should be measured. The research methodology required a scientific explanation of experimental phenomenon which was based upon a cause and effect relationship. The causal relationships encouraged the

formulation of hypothetically assumed general laws of nature. Science proceeded to emphasize the unity of method, based upon the mathematical causal laws which were believed to account for what was observed (Von Wright, 1971). This approach developed into nomothetic research which would allow results to be generalised to a population and would be valuable in this study.

The process of methodological monism resulted in the progressive accumulation of knowledge. The knowledge, built carefully on experiment and observation, generated hypotheses and theories. This process established the dominance of the Cartesian-Newtonian paradigm. However, the validity of this paradigm was rejected by Einstein. The effect of Einstein's discovery entailed the destruction of the old paradigm and a scientific revolution followed (Kuhn, 1962). The old order had been challenged and new explanations for coping with scientific change were now required. Various explanations were suggested to cope with the change and revolutions in scientific laws (Popper, 1959, 1963, 1972; Kuhn, 1962; Lakatos, 1970, 1974). The debate was involved and there is no presumption that it can be adequately reviewed in this thesis. Only the contribution of Popper will be discussed because his explanation became the principal base of medical research methodology.

Popper argued that it was not possible to establish the ultimate or universal truth of knowledge or theories. Therefore:

'Falsifying theories is all that scientists can do. They can never know that any of their theories are true, or even probable. According to Popper, we learn

nothing from science that proves or confirms a theory. The growth of scientific knowledge can only be the growth of knowledge that more and more theories are false. Of those that survive, we can have no justifiable confidence in their truth.' (O'Hear, 1985, p. 43/44)

However, there were facts that deserved more trust than others. They were the facts that had withstood the rigorous test of scientific examination. Popper argued that scientific research should proceed by continually examining facts. The research design should seek to disprove a fact but if the fact could not be disproved then there was more evidence to trust it.

The argument led to a particular research design. The design was controlled by scientists who made an educated guess based upon past experience and past theories and also using creative intuition. The guess was called a hypothesis and was operationalised into a form that could be tested. As mentioned above Popper argued that a hypothesis based upon fact could not be proved to be correct. Popper argued that a null hypothesis should be stated which was the opposite and it was the null hypothesis was tested.

For example, suppose the hypothesis - water freezes at 0 C was examined. According to Popper this could not be proved as an ultimate or absolute truth. Therefore a null hypothesis should be stated which was the opposite - water does not freeze at 0 C. A research methodology was then designed to operationalise this hypothesis. The

experimenter identified the dependent variable - in this case the water, then the independent variable - the temperature. In the laboratory the temperature was controlled by the refrigeration unit and was lowered while the water was observed. At 0 C the water was tested to see if it had turned to ice.

If the water turned to ice then the null hypothesis was rejected. This did not prove that the original hypothesis was true. However, if after many experiments it was found that the null hypothesis was always rejected, then it was possible to put some faith into the truth of the hypothesis. Following this process scientific thought moved forward slowly and cautiously. In many respects Popper returned to the reductionist methods of the Cartesian-Newtonian paradigm.

Popper also argued that a good theory should contain the means for its own destruction: it should be possible to disprove it. Popper admired Einstein, who having hypothesised a highly original theory based upon creative and controversial predictions, then tried to disprove it until it was finally accepted as reliable fact. This approach to scientific research has been called the hypothetico-deductive method. It can provide the scientists with opportunities for the generation of hypotheses. The approach was widely accepted because of its success in the physical sciences and because of the rigour of the methodology it was used in medical science. However, when people were the independent variables the results did not always prove to be reliable. Particularly when the independent variable was a capricious disease like

rheumatoid arthritis.

It was eventually accepted that people were affected in the experimental situation in a way that could be neither predicted nor accounted for by the hypothetico-deductive research model. It seemed that people were affected by the attention shown to them and changes could not always be ascribed to the independent variable. The phenomenon became known as the placebo effect and has been well documented (White et al., 1985). The placebo effect was controlled for in research designs and the controlled double blind crossover research design was the one favoured in medical research. The controlled double blind cross over design was used in drug studies. Neither the patients nor the doctors knew who were getting the tested drug and half way through the study the groups were crossed over.

The scientific research methodology had gained acceptance and there was no theoretical reason why an intervention based upon humanistic psychology should not be evaluated by it, given the limitations of the scientific method. However, it was more applicable to the physical sciences and it did not easily accommodate the irrational and illogical behaviour of human beings. It was hoped that the two different research methodologies would supplement and complement each other's strengths and weaknesses.

In conclusion it has been argued that the new paradigm and the scientific research methodologies have a theoretical base which was essentially different and offered the possibility of interesting contrasts. The new paradigm

method focuses upon people in their strengths and weaknesses, doubts and certainties and tries to illuminate the underlying reasons for their behaviour. The scientific approach focuses upon the common facts and knowledge to establish nomothetic laws that can be applied in all circumstances. Both methods are valuable and will be used. Before the final research design is detailed the previous studies that have investigated group counselling as a therapeutic intervention for patients with rheumatoid arthritis will be discussed.

PREVIOUS RESEARCH

Before the final decision regarding the efficacy of the research design was made, previous research studies were consulted. A number of studies were located in the literature (Henkle, 1975; Udelman and Udelman, 1977, 1978; Schwartz et al., 1978; Kaplan and Kozin, 1981; Shearn and Fireman, 1985; Strauss et al., 1986). A developmental chronological theme can be traced through these studies starting from an interesting idea and become increasingly rigorous in the methodology adopted. The studies will be examined in chronological order.

Henckle, C. (1975) 'Social Group Work as a Treatment Modality for Hospitalised People with Rheumatoid Arthritis.'

This study was conducted by a social worker in a Toronto hospital. The group members were hospitalised patients and the average length of attendance in hospital was three weeks. The hospital normally had between 25-40

patients suffering from rheumatoid arthritis. On average eight patients attended group meetings which were held weekly for one hour. The task of the group was to discuss topics identified by the social worker. The groups were open ended with a continually changing composition. A number of important details are omitted from the paper, for example, the length of the period under investigation and much of the commentary was anecdotal and subjective. The social worker concluded:

'In conclusion, I feel that the group for arthritis patients does, in fact, provide a supportive milieu for inpatients and that the group achieves a number of purposes set down. I feel that, if people are only to find in the group that others understand them and their plight, it accomplishes something important for someone. The limitations of the open-ended, constantly changing, group are evident in terms of trying to effect behavioural and attitudinal changes, but it is felt that, for some, the group presents a good opportunity to test reality, consider alternatives, realise some insight, and gain understanding and acceptance by others. The group certainly gives me, as worker, more insight, empathy, and understanding for the ill arthritic person both in the hospital and in our society.'

(Henckle, 1975, p. 341)

This was an interesting start by a caring and well meaning social worker. As a piece of research on a therapeutic intervention it did have shortcomings. There was no systematic attempt at evaluation, either of group

processes or outcome objectives. The absence of a clearly structured research design did weaken the study. The subjective impressions that form the conclusion provided a generalised statement which can better be described as hypotheses rather than a conclusion. As such it provides hypotheses on which further studies might be based.

Udelman, H.D. and Udelman, D.L. (1977), 'Team Therapy in a Rheumatology Unit and (1978), 'Group Therapy with Rheumatoid Arthritic Patients.'

These two papers appear to refer to one study carried out by a husband and wife team in Phoenix, Arizona. In some respects the study was a replication of the Henckle study. The sample was drawn from hospitalised patients suffering from primary rheumatoid arthritis, but also included osteoarthritis and systemic lupus erythematosus on a random basis.

The open group met for one year and the sample size was 169. The average number of attendances was 2.6 with a range of 1 - 11. The task of the group was discussion of topics suggested by both therapists and patients. The study was subject to the criticisms noted above and its evaluation was likewise anecdotal and subjective.

'We have noted qualitative improvement in mood, adaptation to hospitalisation, communication with family, and rate of convalescence in various patients during the first year's experience.....We feel that further measurements will help to define quantitatively what we see qualitatively.'

(Udelman and Udelman, 1977, p.46)

Schwartz et al., (1978) 'Multidisciplinary Group Therapy for Rheumatoid Arthritis.'

In common with the two previous researchers this study gave no suggestion that group therapy could be described as group counselling. The multidisciplinary nature of the study resulted from the three co-leaders being, a rheumatologist, a psychiatrist and a physician.

A sample of 14 patients was drawn from a rheumatology clinic and some inclusion criteria were defined for the sample. All the patients had classical rheumatoid arthritis and the first six to be selected for the sample were on the basis of age, sex and degree of disability. It is interesting to read their following comments:

'However, as the group leaders and patients became more accustomed to this new experience, a more heterogeneous population was gradually added during subsequent months in an effort to diversify the group.' (Schwartz et al., 1978, p. 289)

It was also noted that:

'During several other sessions children or spouses attended, providing additional perspectives on the effects of rheumatoid arthritis on the family.'

(ibid, p. 290)

It was difficult to decide whether the group should be classified as open or closed and what other characteristics it might have had.

The group sessions lasted for eight months, being held weekly for one-and-a-half hours each. Six patients attended regularly, which was classified as attending two or

more sessions per month. The range for each session was from three to eight patients, four patients came to fewer than five sessions and none attended all the sessions, including the leaders.

The study had stated aims:

- 1) to encourage communication among patients, families and their physicians;
- 2) to improve education of physicians concerning the emotional impact of the disease;
- 3) to present factual material about rheumatoid arthritis to patients and their families;
- 4) to enable the patients to live with their disease more realistically and comfortably.

There was no attempt to operationalise these aims by applying objective tests and the researchers were aware that there was no control. Evaluation, once again, was subjective.

'It became clear to the group leaders that many patients were able to modify their life styles, improve meaningful communication with family, friends, and physicians, increase compliance with physical therapy and medical regimens and, in general, learn to live better with themselves and their arthritis.' (ibid, p. 293)

Considering the research design it was doubtful how much weight can be placed in these conclusions.

One observation was of interest:

'Flare-ups of disease activity coincident with discussions about termination of the rheumatologic

follow-up, and again after ending the group, clearly focused attention on the patient's reliance on and attachment to their physicians. The flare-ups emphasised the supportive nature of the group and the separation anxiety that is implicitly involved whenever a therapeutic team is altered.'

(ibid, p. 293)

The observation was a salutatory warning. It reflects the stress that patients feel and this was corroborated by the evidence from Chapter 2. A counselling intervention was never neutral, it was either therapeutic or harmful (Carkhuff, 1969). Clearly much care must be taken in designing any intervention. The next report in the literature improves the standard of the research design.

Kaplan, S. and Kozin, F. (1981), 'A Controlled Study of Group Counselling in Rheumatoid Arthritis.'

The study has no qualitative evaluation and follows a scientific design, although the nature of the control group was unusual.

A sample of 34 patients self-selected from a population of one hundred rheumatology clinic patients. The population had three criteria:

- 1) the patients had classical or definite rheumatoid arthritis according to the American Rheumatism Association listed in Chapter 1;
- 2) patients were women aged between 21 and 65 years;
- 3) a stated willingness and ability to attend up to 20 weekly sessions.

The sample was then tested on a patient education test and

two psychological tests. The patients were then given a two-and-a-half hour education session by a rheumatologist and an occupational therapist. One week later the tests were re-administered. Then the sample was divided randomly into two equal groups. One of the groups was given group counselling sessions for twelve weeks, whilst the other group acted as a control. Then the tests were re-administered to both groups.

The results showed that both groups benefited from the education session. The final results which were statistically significant showed that only the counselled group had continued to make progress after that. There are obvious areas of confusion in this study although the outcome was encouraging. The group counselling was conducted by a patient with some experience and a psychiatrist was present. Although the counselling was classified as 'non-directive client centred' patients were not permitted to discuss their medical problems and this restriction could only serve to limit their involvement. There were no qualitative evaluation reported.

Shearn, M.A. and Fireman, B.H. (1985), 'Stress Management and Mutual Support Groups in Rheumatoid Arthritis.'

A population of 505 clinic based rheumatoid arthritic patients were invited to take part in this study and 105 accepted. The patients were assessed physically, physiologically and psychologically. The psychological tests were for depression using a little known CES-D scale, developed by the centre for Epidemiologic Studies, Oakland, California and a Visual Analogue 15 cms. Scale for Life Satisfaction (sic). The patients were then randomly assigned

into one of three equal groups. The stress management group was sub-divided into two equal groups to facilitate group working. The aims of stress management were to help the patient identify sources of stress as well as learning relaxation techniques and strategies for coping. The two groups were led by a psychologist who structured and directed all activities. The mutual support group was also sub-divided into two. The aims were to enhance self-responsibility, exchange information, build relationships and attempt to decrease social isolation. The two groups were led by a different psychologist who allowed the group to decide upon the content and direction of activities. The third group acted as a control and did not meet.

The four intervention groups met for 10 weekly sessions each lasting one-and-a-half hours. Ten patients dropped out of the two mutual support groups and average attendance was 8.1 sessions. Nine patients dropped out of the stress management groups where average attendance was 7.7 sessions.

The researchers concluded:

'The study reported herein provides no support for the hypothesis that stress management or mutual support groups improve morbidity or psychological health of patients with rheumatoid arthritis.'

(ibid, p. 774)

The final study had not been reported at the time the research design was being considered but because the results are of interest and mentioned later the details of the study are given. Strauss et al., (1986), 'Group

Therapies for Rheumatoid Arthritis: A controlled Study of Two Approaches.' A sample of 57 patients was drawn from a rheumatology clinic in Los Angeles. They were divided into three groups. The first group was to receive psychotherapy, conducted by a psychologist, weekly for six months and the sessions were not structured. The second group received assertion/relaxation therapy, given by a different psychologist, weekly for three months, utilising a behavioural approach. The third group acted as a control (no treatment). All groups were assessed by a battery of tests on a pre- and post-test basis. 65% of patients finished the assertion/relaxation course and 70% the psychotherapy course.

The researchers concluded:

'In a controlled trial of conventional supportive group psychotherapy or assertiveness/relaxation training for RA patients, we were unable to demonstrate significant improvements in self-report functional status, social or psychological adaptation, psychological symptoms, or disease activity. The lack of positive results could have been influenced by attrition, level of therapist experience, compliance, and sample size. The therapists, though supervised and experienced, were still in training; it is possible that more experienced therapists might have made a difference in outcome. It was possible that our measures were insufficiently sensitive to changes in mood and pain; though well-calibrated in terms of face validity and reliability.' (ibid, p. 1207)

None of the studies discussed above has shown evidence that group counselling was a therapeutic intervention for patients with rheumatoid arthritis. The qualitative studies did not have a rigorous research methodology and the studies based upon the scientific model had weak designs. It would appear that several criticisms can be made of the previous research which are interrelated:

1) the studies have no clear theoretical foundation. Little attention has been given to the philosophical basis upon which the therapeutic intervention was introduced. This omission results in a lack of theoretical perspective and apparent aimlessness of direction;

2) the level of professional expertise provided by the counsellors or therapists was generally unknown. It did appear in some cases to be above the level of the well-meaning amateur. It was mentioned by Strauss et al., (1986) that the psychologists were inexperienced. It may be safely assumed that the psychiatrists acted out of the medical model (Kety, 1974). There was no corroboration that an attempt had been made to match the philosophical orientation of the intervention with that of the counsellor or therapist. Clearly this was an important variable;

3) open groups are unlikely to provide an atmosphere of support, trust and confidence. Open groups do not form the group-as-a-whole identity to which patients can relate. They cannot continually repeat the exercises that produce the group-as-a-whole identity. Without this approach progress was limited by the superficial depth to which

patients feel psychologically safe to go. Chapter 2 revealed the intimate nature of many of the psychological problems that patients faced and it was unlikely that they would be prepared to discuss them in an open group when attendance was limited to two or three sessions.

4) the composition of the groups varied. The number of members ranged from 3 - 20. The extremes of this range are not suitable for group counselling. It is generally acknowledged that the optimum number was in the range 8 - 12 (Douglas, 1979) although there was no universal agreement;

5) there was considerable variation in the length of the counselling intervention. In the closed groups this ranged from ten weeks to eight months. In the open groups the range was not so important, Henckle (1975) does not mention the length of time, Udelman and Udelman (1977, 1978) state a twelve month period;

6) qualitative evaluation, when used, was very subjective. No attempt was made to use any of the new paradigm methodologies. Whilst it was acknowledged that these methodologies had weaknesses they were based upon arguments that did give more weight to the findings. New paradigm methodologies would have allowed for a more systematic study of the processes that the groups went through;

7) the studies that followed a scientific design did not use the same questionnaires. The validity and reliability of some questionnaires seemed doubtful and other psychological measurements seemed crude and inappropriate. The nature of the control group seemed a matter of debate.

In the Kaplan and Kozin study (1981) the control group was also a treatment group, whilst in Shearn and Fireman (1985) the control was a no treatment group. There appears to be undue emphasis upon outcome measurement which ignores the effects of group processes.

'There is little doubt that these investigations have been pursued at the expense of other research where processes rather than labels might have been more fruitfully investigated.' (Skevington, 1986, p. 569)

A lot had been learnt from the previous research studies. It was noticeable that the research designs had become more sophisticated, but there was no indication that attention had been given to the theoretical foundations of the research methodology or the counselling intervention similar to the beginning of this chapter. Many of the variables were not clearly identified and the interventions were vague and unstructured. These reasons undoubtedly contributed to the negative quantitative results. It is argued that for those reasons a further study is justified that clearly identifies the variables and structures an appropriate intervention.

RESEARCH DESIGN

Details of the research design to be adopted for this study will be discussed under the points 1 - 7 mentioned above. It is argued that :

1) the philosophical foundation for the study was discussed in Chapter 3 and it was argued ^{that} the group counselling based upon humanistic psychology offered the

most flexible and facilitative basis;

2) two group counsellors would be used to lessen the individual bias. Each would have their own group. The group counsellors would be experienced and proven counsellors with a professional qualification in counselling. The group counsellors would be members of the British Psychological Society, Counselling Section, or the British Association for Counselling. In addition it would be necessary for the counsellors to be sympathetic to the principles of humanistic psychology and to support those principles as their primary belief and value system;

3) it was decided that the groups should be closed. This was preferable to open groups where the constitution would change if members dropped out and were replaced. The risk was that too many members would drop out and then the group would be too small to act as its own resource. If the argument of Chapter 3 was correct then patients would find group counselling a therapeutic process and would attend for the period of the study;

4) group size was fixed at ten patients each. It was thought that groups of patients who had been socially isolated might find exposure in a group an intimidating experience. If the number was fixed at twelve too much time would be spent facilitating patients making contact with each other. The figure of ten allowed for two drop-outs and this seemed the most prudent decision;

5) after consultation it was decided that six months was the optimum length for the group counselling. Counselling sessions would be held weekly and last for one hour. It was felt that anything less than that time

allocation would not allow the issues to be discussed. If they were longer than an hour the patients would suffer because many needed to move around to prevent stiffness making them very uncomfortable. These time periods were satisfactory from the counselling point of view as it allowed relationships to develop and gave the opportunity for the group to make progress. It also provided sufficient time for the qualitative aspects of the study to be recorded, observed and discussed. More details of this process will be given in point 6.

The consultant rheumatologists advised that six months was also a reasonable length of time. If patients were to change then it would be possible to observe any physical or physiological changes at the end of that period. Details of the measurements that were to be taken are given in point 7;

6) it was evident that the processes that the groups went through were an important aspect of the research methodology. An evaluation of the processes would provide valuable information and a record be made of it (Scaife, 1979). It was decided to record all of the group counselling sessions on video tape and to make a systematic analysis of it (Smith, 1980). The decision to do so was an important one and was taken for the following reasons:

- a) a qualitative analysis of the interaction within the group could be made;
- b) it provides a retrospective means of analysis (Hardin et al., 1983);
- c) non-verbal communication could be observed;

- d) patients could be shown sequences of their own contributions and invited to explore comments in greater depth (Robinson and Jacobs, 1970);
- e) an analysis of group developments could be made (Lockwood et al., 1978);
- f) the internal dynamics of the group could be observed and analysed.

The video tapes were to be viewed independently by the researcher and counsellors, then discussed at their weekly meeting. The meetings were in turn to be recorded on audio tape and a secretary was to compile minutes. The process would allow a complete data base to be established and a record of the research to be available.

It was decided to involve the patients in the analysis of the process. It has already been shown in quantum theory that the experimenter influences the subject of inquiry. This process has been acknowledged in qualitative evaluations:

'Since the studies of Orne, and Rosenthal (1966) it appears indisputable that the humanness of both the experimenter and the subject interest in numerous ways which are likely to have a profound effect on experimental outcomes. The experimenters' appearance, sex, age, mood, manner, race, social class, dialect and dress are all likely to influence the subject so that instead of the experimenter being an external 'objective' observer, he is, in effect a participant who actively contributes to the behaviour that he wishes passively and

objectively to observe and record.' (Graham, 1986, p. 108)

By involving the patients in the research the influence that the researchers had upon them was more likely to be disclosed.

'The way of co-operative enquiry is for the researcher to interact with the subjects so that they do contribute directly to hypothesis making, to formulating the final conclusions, and to what goes on in between. This contribution may be strong, in that the sense the subject is co-researcher and contributes to creative thinking at all stages. Or it may be weak in the sense that the subject is thoroughly informed of the research proposals at all stages and is invited to assent or dissent, and if there is dissent, then the researcher and subject negotiate until agreement is reached. In the complete form of this approach, not only will the subject be fully fledged co-researcher, but the researcher will also be co-subject, participating fully in the action and experience to be researched.' (Heron, 1982, p. 19-20).

It was not envisaged^{that} the patients would be involved in hypothesis making but their co-operation in the formulation of conclusions was to be sought. This process was respondent validation and was used by ethnographers (Bloor, 1978; Ball, 1982).

'Some ethnographers have argued that a crucial

test for their accounts is whether the actors whose beliefs and behaviour they purport to describe recognise the validity of those accounts.' (Hammersley and Atkinson, 1983, p. 195)

The conclusions would be statements regarding the process and evaluation of the research. These statements were to be reached by a process of compromise and negotiation by everybody involved in the research.

It has been maintained that the process of compromise and negotiation could be helped by encouraging openness and dialogue between experimenter and subject and in effect treating subjects with full regard to their humanness and subjectivity. It has been argued elsewhere that the more the experimenter disclosed to the subject about the aims and purposes of the research the more honest was the subject and the more reliable were the results obtained (Jourard, 1971).

Confidentiality and trust were essential components in the research and comprise an important methodological element of new paradigm research. Patients were to be given a signed statement identifying the objectives, implications and expectations of the project (Appendix A). The statement would carry a guarantee that all information and proceedings, including the video tapes would be treated in full confidence and would not be released without negotiation and guarantees of anonymity. By this process it was hoped that accurate qualitative conclusions could be reached.

7) as was stated above the research was being

conducted in a medical arena and if it was to have validity it had to satisfy the criteria of a scientific methodology. The components of that methodology are, population and sample, tests and control group. They are now discussed.

Population and sample. For the purposes of the research the population was defined as those people suffering from rheumatoid arthritis, either classical or definite on American Rheumatological Association criteria, living in the geographical area approximating to Northumberland and Durham County Boroughs and the Metropolitan Area of Tyne and Wear. The population was largely hospital based but did include some general practice patients.

The population was centred largely upon two hospitals. One of the hospitals was a university teaching hospital and led to a possible bias in the sample. It has been found that:

'Patients referred to the clinics of university teaching hospitals for evaluation are almost always particularly difficult chronic pain patients not deemed suitable for referral to or treatment in other local programmes.' (Roberts and Reinhardt, 1980, p. 152)

Therefore two hospitals were used in order that the sample was as representative as possible. No attempt was made to refine the inclusion criteria. It has been noted that chronic disease patient groups are often viewed as a single homogeneous population whilst in fact they are heterogeneous groups with a wide range of demographic characteristics (Meyerowitz, 1970; Fordyce, 1976; Bradley

et al., 1981).

A sample of 30 patients was to be drawn from the population. The sample would be drawn on an incidental basis (Guilford and Fruchter, 1973) from patients attending out-patient clinics at the Royal Victoria Infirmary and the Freeman Road Hospital, Newcastle upon Tyne. The following exclusion criteria would apply:

- 1) patients who were undergoing psychiatric care;
- 2) patients who were about to undergo psychiatric care;
- 3) patients who had been recommended for psychiatric referral;
- 4) patients with language problems severe enough to make effective communication improbable;
- 5) patients who were bedridden.

Patients would be invited to join the programme and they would self select. Patients would then be given a number of tests before being randomly assigned to one of three groups.

Tests. Two different measures were to be taken in a pre- and post-test design. These were clinical and psychological measures respectively.

The clinical measurements were to be taken by the consultant rheumatologists and a metrologist. The clinical measurements were to include the Ritchie Articular Index which measures tenderness at the joint margins (Ritchie et al., 1968). Measures of pain and stiffness were to be taken on a visual analogue scale. Laboratory measurements of disease activity include, haemoglobin, erythrocyte sedimentation rate, white blood cell count and platelets.

The psychological instruments of measurement were selected because of their proven reliability and validity or because of their specificity for rheumatoid arthritis or both. The measures were capable of identifying changes in the patients' psychological condition at the end of the group counselling. The measures were:

1) Arthritis Impact Measurement Scale (Meenan et al., 1982) (Appendix B). The scale was a widely used measuring instrument with accepted reliability and validity (Liang et al., 1985). It was a comprehensive questionnaire which assesses the total impact of arthritis upon a patient's life. It had sub-scales that included: mobility, physical activity, dexterity, household activity, social activity, activities of daily living, pain, depression, anxiety and health perception.

2) Locus of Control Scale (Wallston et al., 1978; Nicassio et al., 1985). These scales measured the patient's perception of the degree of control they had over medical outcomes. The Arthritis Helplessness Index (Nicassio et al., 1985) (Appendix C) gave a single measure over the degree of control patients perceived they had of their medical condition. It was a new measure and did not have proven reliability or validity but it was designed specifically for patients with rheumatoid arthritis. The Health Locus of Control (Wallston et al., 1978) (Appendix D) was a more generalised instrument. It had three sub-scales and measured: a) the degree to which patients believed they were in control of their health; b) the degree to which they believed their health care was a matter of chance; c) the

degree to which powerful others in their lives controlled their health.

3) Depression Scale (Beck, 1961) (Appendix E). It was noted in Chapter 2 that depression was one of the psychological concomitants of rheumatoid arthritis. Depression was measured by the AIMS questionnaire but only as a sub-scale. Because it was such an important factor and one that might be altered by group counselling, a general standardised measure was also used.

4) Pain Scale (Melzack, 1975). Pain is an important aspect of any disease and is of particular relevance in rheumatoid arthritis because the diagnostic criteria includes it. There was a considerable literature on pain (Moldofsky and Chester, 1970; Pilowsky and Spence, 1975; Pilowsky and Bassett, 1982; Charter and Nehemkis, 1983; Melzack and Wall, 1984; Nehemkis and Charter, 1984; Charter et al., 1985; Wagstaff et al., 1985). This literature confirmed the complexity of the pain concept and acknowledged that it could be assessed on a number of different dimensions. The McGill Questionnaire (Appendix F) explored sensory experiences of pain, affective characteristics of pain and evaluative judgements of pain. It has been used in a wide range of diseases (Reading, 1982).

The pre- and post-test design will generate data on the clinical and psychological measures. The data will then be analysed to evaluate the effectiveness of the group counselling intervention. Statistical testing will be by non-parametric analysis to establish levels of significance. Due to small sample size levels of statistical significance

may not be achieved, in which case analysis will be by observation.

Upon completion of the pre-test questionnaires the sample would be randomly assigned to a counselling group or the control.

Control.

'It is now recognised that meaningful scientific research requires objective data and control group comparisons.' (Watson and Kendall, 1983, p. 44)

Control groups were required for three main reasons:

1) spontaneous remission can occur in rheumatoid arthritis and it was possible that group counselling might wrongly be described as the remedy;

2) it has been shown that some patients would exhibit some improvement simply because they expect to get better (Brena et al., 1980);

3) the increase in attention and interpersonal interaction provided to patients by most psychosocial interventions can result in physical or psychological improvement independent of the intervention (Lucas, 1976).

The validity of a control group was not without problems. The variable nature of a control group has been commented upon (LeMay and Christensen, 1968; Wilkins, 1985, 1986). In addition the constitution of the best control group has been a matter of debate. Researchers have adopted a number of different arguments and control groups have been taken from:

1) physically healthy people whose medical condition is unlikely to change over the

research period (Spergel et al., 1978);

2) immediate family members who have not been diagnosed as having the disease (Moos and Solomon, 1965);

3) patients suffering from chronic diseases other than rheumatoid arthritis (Watson and Kendall, 1983);

4) patients with early rheumatoid arthritis where the group under investigation are patients of several years standing (Robinson et al., 1972).

For the purposes of this research the control group were to be taken from the population identified above.

The question of whether the control group should meet had also to be considered. The independent variable was group counselling and not the addition of a group counsellor. If the independent variable had been a group counsellor then the control would have been a group without a counsellor. In which case the group would have had to meet. If a group had met then it would be regarded as a self help group. Self help groups have been shown to be therapeutic and therefore would not provide a satisfactory base line against which a counselled group could be measured (Robinson, 1985).

It was accepted that this argument was not unassailable. Two practical points were to lead however to its acceptance. Firstly it would have seemed unreasonable to ask patients suffering from rheumatoid arthritis to meet once a week for six months without anything to offer them. Secondly at this early stage there was an argument for using

the most favourable design. If the counselled groups did not show a difference from the control it would be a clear indication that counselling should not be pursued as a source of therapy.

The nature of the control group has been discussed. It was evident that the logic for the control group in scientific studies did not easily translate into qualitative methodology. The scientific studies could use control samples originating from the same tissue or similar. This was not the same in qualitative studies. It was valid, for the reasons stated above to have a control measure but it would be better referred to as a comparison group. The difference in measurements could only allow comparisons to be made rather than conclusions strong enough to recommend acceptance or rejection of a hypothesis.

SUMMARY

It has been argued that the most effective research design will combine elements of new paradigm and scientific research methodologies. These two research models will allow qualitative and quantitative data to be generated. The data will be fundamentally different. The qualitative data will be subjective and phenomenological and will be evaluated by a process of triangulation and respondent validation. The quantitative data will be objective and factual. The quantitative data will be evaluated by assessing differences in scores on the pre- and post-test measures. Calculations will be by non-parametric tests of statistical significance.

The two basic elements in the research design will

facilitate the final evaluation of the group counselling intervention. The two elements are essentially different and their respective strengths and weaknesses will be compared and contrasted in arriving at the conclusions. The research design can now be operationalised and the field work is described and discussed in Chapter 5.

PART 2

PART 2

Part 1 investigated the historical, philosophical, psychological and research background to the project. It concluded that humanistic psychology offered the most appropriate foundation upon which the group counselling intervention could be based. Part 2 describes the way in which the research design was operationalised and the conclusions of the project. Chapter 5 discusses how the research design was operationalised and how the project was administered. Chapter 6 describes the quantitative and qualitative results. It notes that the two sets of results do not agree and it describes how the final set of conclusions were arrived at.

Chapter 5

INTRODUCTION

The previous chapter discussed the theoretical and practical considerations which determined the choice of a research design. The research design having been selected was operationalised and this chapter describes that process. It gives an account of how the sample was selected and how the venue was chosen. The group counselling sessions were video recorded and these were discussed and a record of the groups' progress kept at the weekly meetings of the researcher and the group counsellors.

The researcher and group counsellors noted that the groups progressed through four interrelated stages. The four stages were ice-breaking and climate creation,

information exchange, self disclosure, and enhanced self-esteem and self-concept. These four stages differed from those suggested by other studies (Homans, 1950; Rogers, 1970; Bennis and Shepherd, 1974; Blumberg and Golembiowski, 1976; Tuckman and Jensen, 1977; Lakin et al., 1981; Gazda, 1984; MacKenzie and Livesley, 1984). The first stage of ice-breaking and climate creation was the only one that had been predetermined. It would appear that the second stage, information exchange, was unique to groups of patients with a chronic disease. During the third stage patients self-disclosed information about themselves at a deep feeling level and this permitted them to move to the final stage which the patients found therapeutic. The four stages are illustrated by episodes which give details of the patients' contributions to the groups.

The chapter closes with a summary of the fieldwork. The conclusions that can be drawn from the fieldwork are present in the following and final chapter.

SAMPLE

A sample of thirty patients was to self-select on the basis of an incidental sample (Guilford, 1973). The researcher started to draw the sample in October 1985. The researcher attended clinics at the Royal Victoria Infirmary, and Freeman Road Hospital, Newcastle upon Tyne where consultant rheumatologists were requested to refer patients coming within the inclusion criteria to the researcher.

The patients who were referred by the consultant rheumatologists expressed an interest in the project.

Thirty-three patients were seen to draw the sample of thirty. Three said they would not take part. They were all male and in their seventies. One gave no reason, another said in a slightly embarrassed manner that he did not want to return to school. This comment was probably made because the researcher introduced himself as belonging to the School of Education, Durham University. The third said he would have been interested but his dog occupied all his time and he did not want to leave it. The dog was obviously part of an important coping strategy for him.

During the initial interview the researcher wanted to emphasise three areas of concern to the patients.

1) to draw a firm distinction between the consultant rheumatologist the patients had just come from and the researcher. It was important the patients understood that the researcher was not part of the medical profession. The researcher introduced himself as belonging to the School of Education, Durham University and added that he was not connected with the hospital, except for the purposes of the research.

The researcher hoped to establish a relationship of confidentiality and trust with the patients and it was important that they did not think the researcher could influence their medical treatment, nor that the researcher had any influence with their consultants. Patients may have agreed to participate in the project because they thought their consultants wished or desired them to do so. There is evidence to sustain the belief that patients follow their medical regimen because they fear that if they do not, the doctor will deprive them of effective medical care (Ford and

Castelnuovo-Tedesco, 1977).

2) that patients were fully aware of the areas that the research was interested in investigating. It was explained to patients that the areas concerned the fact that some people coped better with the disease than others. The research was to try and discover why some patients coped better. The research was interested to discover:

- a) whether group counselling would be able to identify why some people coped better;
- b) whether group counselling would be able to help patients to cope better.

3) patients were asked not to make an immediate decision. It was explained that the project would demand a large time commitment - one hour per week for six months. It was emphasised that this commitment could only be undertaken with the support and consent of family members. The patients were asked to go home and discuss the matter with the family members or relations who would be involved. It was explained that one of the reasons for this caution was the nature of the research. The patients were told that the groups were to be closed, so that if they dropped out a substitute could not be put into their place. The patients were advised that whilst no pressure was being put upon them to accept, it was hoped that if they did, they would see the project through to the end unless unforeseen circumstances prevented them. Where possible, the patients were seen with their spouses and the project was explained to both. Where this did take place the spouses seemed keen to encourage the patients to involve themselves in the project.

There were a variety of responses to this initial approach. Some patients were keen to accept the offer straight away. Some were keen to talk about their problems and how they related to the idea of the project. Some said that there was a need for psychological support which was at that moment unmet.

If the patients had not given a blood sample it was requested that they did so because this could prove to be difficult to get after the event. The initial interview closed by the researcher thanking them and saying that he would get in touch in about a month to six weeks time to see what final decision they had made.

Demographic details were taken from the patient's file at this point. The incidental sample gave six men and twenty four women. This suggested that it was not representative of the population suffering from the disease. It has been accepted that the proportion of the population was one third men to two thirds women (Wood, 1986), however this proportion did not extend across all age bands (Anderson et al., 1985). There was no attempt to match the sample for disease severity. The information contained in the file was variable and in certain cases important pieces of information were missing. The sample was contacted approximately one month to six weeks later and asked if they were still interested in taking part in the research. All confirmed they were.

Various pieces of measurement were to be collected to satisfy the scientific design. The clinical measurements had already been taken. The psychological questionnaires

were to be given to the patients at the first group counselling session. The patients were requested to complete them and return them at the second session. They were advised not to answer all the questionnaires together but to spread them out over the week. All of the questionnaires were returned.

TRAVEL EXPENSES

In order that all patients would have an equal opportunity to self-select offers of financing travel expenses were made. Most patients said that they would be brought by a family member but some did accept the offer. One patient said that because she worked during the day the only way she could get to the group counselling sessions would be by taxi. The necessary arrangements were with a local taxi firm.

Once the group counselling sessions had commenced it became apparent that the Tyne and Wear Social Services Department provided a passenger service. 'Dial-a-Ride' was a free service that transported patients throughout the area. The service was strictly for non-medical journeys because ambulance drivers had complained that it was being used for hospital appointments and they feared for their jobs. There was some controversy as to whether the patients' journeys were non-medical.

The researcher telephoned the 'Dial-a-Ride' Centre and discussed the matter with the manager. It was readily accepted that the patients' journeys were non-medical and they agreed to transport the patients. The patients were asked to identify themselves when they rang to book

transport as belonging to the CARE project. CARE was a acronym for Counselling and Arthritis Research Evaluation. This personal identification gave a feeling of importance to some patients which they appeared not to have experienced before.

VENUE

The venue was considered to be an important factor in the research. The subject of the research was non-medical and there was no reason why it should have been situated in a medical setting. The patients were used with attending the hospital and obvious associations would influence their approach to the group counselling sessions. This influence could contaminate and bias the results. It was thought better that a neutral setting should be found.

Various settings were considered. There had been a centre for counselling near the hospital but unfortunately it had recently become redundant. A number of rooms that the Rheumatology Department controlled were viewed but for a variety of reasons, particularly size, they were considered unsuitable. It was thought to be important that the project disassociated itself from the medical aspects of patient care. A great deal of effort was made to secure a venue away from the hospital but without success. It was finally accepted that a room in the hospital would have to be used for the following reasons:

- 1) as the counselling sessions were to be video recorded accessibility for equipment was important;

- 2) access to the building and the room, plus facilities had to be considered; ramps, lifts, wide corridors and doors, and toilets were essential;
- 3) the room had to be quiet as noise would affect the video recordings;
- 4) the room had to be adequately lit;
- 5) the patients needed a room where they would feel psychologically comfortable and that promoted an atmosphere of confidentiality and trust;
- 6) the room had to be central for the sample;
- 7) no financial expenditure could be incurred.

A room was eventually located that satisfied the criteria detailed above. It was in the New Medical School at the Royal Victoria Infirmary. The New Medical School was a new building and unfamiliar to the patients. Geographically it was separate and isolated from the hospital with a separate entrance. The room was on the fourth floor, approached by lifts. It was large with bare walls and no windows, offering few distractions.

VIDEO RECORDING

The Audio Visual Centre at the Medical School had agreed to provide video equipment. The equipment was sophisticated and the possibility of refined recordings became possible. The room was large enough to accommodate more than one camera, however this possibility was rejected for the following reasons:

- 1) the group were to sit in a circle and to adequately record everybody would have involved

the use of four cameras. This would have made the cameras too obtrusive;

- 2) the Audio Visual Centre were prepared to set up the equipment but were not prepared to provide a technician to operate it;
- 3) the presence of an operator would have been an unnecessary distraction;
- 4) visual information was not considered to be as important as audio.

The groups were to sit in a circle around a coffee table. Two audio microphones were to be placed upon the table. The two microphones would be capable of picking up voices at quiet moments of intimacy and personal reflection.

ETHICAL COMMITTEE

An application had been made to the Medical Research Council for research funds to finance the project. The Medical Research Council required confirmation that approval had been sought from, and been given by, the local ethical committee before they would consider the application. The researcher contacted the local ethical committee and was advised that an application should be made on the appropriate form which was duly forwarded by post. The researcher completed the form giving due recognition to the spaces on the form. This response was to turn out to be totally inadequate.

The consultant rheumatologists had not mentioned the ethical committee and the researcher had been unaware of its existence until that time. In fact approval of the local

ethical committee would have been unnecessary because the group counselling intervention was not going to interfere with the patients' medical regimen. For this reason it had not been mentioned by the consultant rheumatologists.

The ethical committee considered the application at their next meeting and rejected it on the grounds that there was insufficient information. This rejection was to cause some anxiety for the consultant rheumatologists. The local ethical committee was considered to be extremely important for them as it governed all of the studies that they undertook. It resulted in a sharply worded reprimand to the researcher (Appendix B).

Re-application had to be made and the researcher and Reader in Rheumatology had to appear before the local ethical committee to answer queries. Fortunately this meeting satisfied the committee and permission for the project to proceed was given. The confusion and trouble were innocently encountered. It illustrated that no matter how thorough the research process was planned there could always be misunderstandings, particularly when the research was of a collaborative nature and crossed the boundaries of separate disciplines which usually adopted different research methodologies.

GROUP COUNSELLORS

The research design stipulated that two group counsellors would be needed. At this interface between theoretical research designs and practical issues the researcher was fortunate. The word 'fortunate' sits

uncomfortably in a research thesis however given the practical implications it is apposite. The possibility of finding two counsellors who were prepared to commit themselves for six months to the weekly time involvement together with the anxiety associated with research was not considered to be high. The counsellors would not be recompensed and their personal commitment to the research would be an important factor.

There were further limitations on the choice of counsellors. The counsellors had to adopt a style of counselling that was sympathetic to humanistic psychology. This approach could be identified within a client-centred framework. Two counsellors were suggested and they were approached. They had both been trained in academic and practical counselling skills at the same institution to masters degree level. Both were in full time employment in Colleges of Further Education where their jobs concentrated upon counsellor training and practical counsellings. Both were women, were known to each other and recognised a degree of commonalty in their approach to counselling. Neither had experience of counselling in medical settings, but they were familiar with group work. Fortunately both accepted.

THE GROUPS

The sample of 30 patients were randomly assigned to one of three groups. There was no attempt to match the groups.

	Name	Age	Sex	Marital Status
Group 1				
	Pat P.	29	F	Married
	Joan W.	55	F	Married
	Alma J.	56	F	Married
	Helen B.	57	F	Married
	Rita F.	55	F	Married
	Agnes R.	55	F	Married
	Alex M.	66	M	Single
	Margaret P.	55	F	Married
	John D.	63	M	Married
	Dave G.	40	M	Married

Group 2				
	Audrey R.	70	F	Widow
	Ida S.	56	F	Single
	Maureen M.	45	F	Married
	Jennie M.	50	F	Married
	Doreen H.	62	F	Widow
	Josie C.	46	F	Married
	Edna C.	63	F	Widow
	Sarah M.	59	F	Widow
	Dorothy D.	70	F	Married
	John R.	35	M	Single

Control				
	Margaret J.	45	F	Married
	Monica F.	38	F	Married
	James A.	63	M	Married
	Jemina P.	45	F	Single

Gordon H.	56	M	Married
Maureen B.	55	F	Married
Ann S.	55	F	Married
Marilyn F.	58	F	Single
Joyce B.	61	F	Married
Doreen A.	57	F	Married

(Group 2 was reduced to 9. John R. never attended. He telephoned to say that his father had a stroke over the Christmas holidays and he was staying at home to care for him. He said that he hoped to get to the next meetings. He apologised after each meeting. By the end of the fourth meeting he decided that he would not be able to take his place and dropped out. The group had made considerable progress by this stage and it was decided not to introduce another member).

ADMINISTRATION OF RESEARCH

The research design required that a record of the progress that the groups made was to be kept. This was principally done by the group counselling sessions being video recorded. These recordings were analysed each week as the group counselling proceeded. The group counselling sessions were held on Monday evening and Tuesday afternoon. As soon as the sessions were over the video tapes were duplicated. One tape was given to the group counsellor and the other was retained by the researcher. Both watched the tapes independently. The researcher made an analysis of the tapes. This analysis recorded:

- 1) the topic under discussion or silence;

2) the time devoted to it;

3) the way in which the topic changed (Bebout and Gordon, 1972).

The video recordings were not a complete or definitive record of what had taken place. It was soon apparent that the tapes gave little indication of the feelings that the group had shared particularly during periods of silence. The recognition of shared feelings in silence was a significant development in the groups progress. Important observations, comments and information were supplied by the counsellors at the research team's weekly meeting. Without this knowledge it would not have been possible to fully understand the behaviour of the groups.

The researcher and counsellors watched the tapes independently during the week and kept notes on points of interest. Every Friday the researcher and group counsellors met to review progress. The discussions allowed every member to contribute. It soon became evident that everybody had their own phenomenological understanding of what had taken place. Each contribution added a different perspective. The discussions were evidence of triangulation which allowed a more comprehensive understanding to be arrived at (Adelman, 1977). Initially the meetings lasted two to three hours, however as the research progressed the meetings became longer, lasting some five hours. The meetings were audio recorded and the tapes were used as a basis for a set of minutes compiled by a secretary who was also present. These minutes were duplicated and given to the researcher and the group counsellors. The minutes of the meetings together with the video recordings were the data base upon which the

progress of the groups was evaluated.

The formative evaluation of the project which was carried out at the weekly meetings of the research team established that the progress of the groups could be divided into four stages. The four stage were ice-breaking and climate creation - (this stage was initiated by the counsellors); information exchange; self disclosure; and enhanced self-esteem and self-concept. Both groups followed these developmental stages and each stage lasted for approximately 6-8 weeks. This assertion was made tentatively because it would be unrealistic to draw too many conclusions from it, but it was worth stating.

The stages appeared to be developmental, discrete and sequential but a rigid framework was not implied. There were occasions when individuals within the groups did not move at the same speed as the group. Once the groups had taken on their group-as-a-whole identity it was apparent that they moved at their own speed, which was not that of its slowest member. Some members seemed to encourage the group to take risks whilst others appeared reluctant to initiate discussion. The groups soon established their own momentum and they progressed at that speed. It was also apparent that members and groups moved from one stage to another and they did not always follow a linear development. The four stages will now be illustrated and discussed.

ICE-BREAKING AND CLIMATE CREATION

Patients were sent a map of how to arrive at the New Medical School and they were all able to follow the directions. Because the room was difficult to find the patients were met in the foyer and taken up to the 4th. floor. Patients were encouraged to move into the seats so that the project might commence. The research team were anxious at this early stage that group norms did not develop which were dysfunctional. It was hoped that assembly would be prompt and patients would be seated in the circle in order that the video recording could commence so information was not omitted from the tapes. The sessions were to be kept to one hour, promptly started and finished.

The beginning of this first stage was the only one that was planned. The counsellors tried to create an atmosphere that was congenial, warm, relaxed and friendly. The project, although a serious piece of research, did not need to be conducted in a serious atmosphere. The members of the groups had a chronic illness that often caused intractable pain. It was hoped that the six months would be an enjoyable experience.

The initial sessions were as informal as possible. Patients were to be introduced by way of games which were carefully thought out as inappropriate games could endanger future progress (Lakin et al., 1983/84). The group members were divided into pairs to begin with, group activities may have been too threatening. Once patients felt comfortable in pairs then they were encouraged to communicate with the whole group.

Space was an important consideration. The

ownership of space was a crucial factor in the groups' development. Under normal circumstances the counsellors would have had the members of the group move around so that they did not form the habit of sitting in the same chair and communicating only with the person on either side. Open communication within the group was important. The physical condition of the patients prevented such activities. It was not feasible to expect them to move around within the group when movement was painful.

The initial meetings were characterised by nervousness and apprehension. This seemed to be associated with two different factors:

1) the patients were not sure what their role was. Previously some had taken part in pharmacological research where their role was passive and they were treated mechanistically. They were now required to be more active but little direction could be given by the counsellors. It was important that patients felt they were partly in charge and responsible for the groups but this tended to create a leadership vacuum which made them feel uneasy.

2) there was little evidence of interpersonal skills with some patients. In most cases the patients lived alone and it was subsequently established that they had few social or family contacts. Rheumatoid arthritis disrupted social and family relationships and patients became isolated as the evidence of Chapter 2 showed. This process made the practise of normal interpersonal skills problematic. It was evident that some members of the groups found mixing with nine strangers unnerving. Patients were also interested to

discover who the members of their group were which may have resulted in them observing rather than actively participating.

The aims for the first sessions were that they be enjoyable, social and relaxing. It was recognised that the counsellors were to be directive in these initial sessions. The counsellors advised the group about the process of counselling and what it entailed. Patients were told that they could opt out of any activity or discussion and that they were entirely free to be as private in the group as they wished. They were advised that they would not be asked to participate in any physical activity and if they found anything painful they were requested to mention it. They were instructed about the counselling round and the purpose for it. They were also advised that they could pass at any time.

The introductory sessions included activities which were participatory and these generated much hilarity, however, much of the laughter was nervous. It was evident that the patients had strong motivational drives. They were keen, willing and enthusiastic to follow instructions. There were occasions when the group divided into diads and triads and at these moments the counsellors lost control. It was appreciated that the group would have to practise self discipline and only one person would be able to talk at once. The group needed the opportunity to practise the 'round'.

A friendly and pleasant atmosphere was created. Whilst this was an indication of success for the first session, it was recognised, even at this early stage, that

patients should feel comfortable about expressing negative and painful thoughts. If this climate was not created then patients would get the wrong impression about the nature of group counselling. They had to feel comfortable about expressing negative and painful thought otherwise a biased data base would be established.

One group questioned why they were there towards the end of the first session. It was an important question for them and they wanted some indication of the aims of the group. The counsellors found it a difficult question to answer because nobody was sure what to expect. The patients' contributions were to be the data base for the research and whatever they contributed to the sessions was regarded as satisfying the aims.

This phenomenological approach had been one of the reasons for incorporating a new paradigm research element into the design as discussed in Chapter 4. The group members were not easily diverted from this area of concern. There were some important questions that they wanted to ask.

The counsellors soon found it was easy to forget that the group members were in continual pain. This was reflected in society generally which wishes to ignore the fact (Blaxter, 1984). The pain lead to anger and frustration which was to be a reoccurring theme and a constant reminder of the stress and tension associated with a chronic illness. The counsellors did not reflect those feelings at this early stage and they were unsure when to intervene or stop activities.

In the second session Group 1 was asked to write a

list of hobbies and interests. This list was extended into an exercise which generated a great deal of suspicion and anxiety. The group could not accept the reason for the exercise as given and thought it was an attempt to test I.Q. Whilst this suspicion was totally unfounded and fanciful it was a reminder of the insecurity associated with a chronic illness. The patients were aware that the cause of the disease was unknown, therefore anything that might be the subject of investigation could be the cause. It was an illustration of the logical arguments that people could develop to explain situations but which appear totally unreasonable to other people. The incident was a salutary reminder to the research team about the use of empathy.

The counsellors of both groups continued with exercises aimed at deepening the level of feelings that patients felt they could communicate to the group. The feelings that were identified regarding the disease were:

- a) the 'shame' associated with having a chronic disease;
- b) the guilt women experienced passing the disease on;
- c) the lack of confidence when outside;
- d) the feeling of holding 'normal' people back;
- e) the threat to male identity that physical disability caused.

The exercises increased the cohesiveness of the groups and they began to move towards the point in time when they would take on their own identity.

The question 'Why are we here?' was repeated on several occasions. The counsellors answered it by explaining

that everybody in the group had rheumatoid arthritis and that the normal helping response they experienced was one concerned with medicine. The group now provided the opportunity to explore a different response and to try and determine what patients could do for themselves. Many patients said that they were happy to participate in the research but claimed that they did not expect to gain any benefit from it. This lack of expectation could have influenced the neutral quantitative results presented in the final chapter.

During this first stage it became obvious that the groups were different in character and temperament. Group 1 were more noisy and displayed feelings of anger, frustration and assertiveness. There were three men in the group who may have had greater difficulty in coming to terms with the fact they had a chronic illness (Brattstrom and Larsson, 1983). Four members were in paid employment and Chapter 2 had presented evidence that employment changed the perspectives of patients (Katz et al., 1968; Lee et al., 1974). Group 2 were quieter, more passive and less self-confident. They were slightly older on average than Group 1, single sex and were not in paid employment, 4 were widow's.

The two counsellors were concerned that a number of issues were being raised in the initial stage and they were not clear how they should respond to them. The issues that the patients' mentioned were isolation, loneliness, boredom, frustration, shame, the dilemma of a chronic illness and the psychological need to develop coping strategies. These issues were very personal and were

experienced by the patients at some psychological depth. There was a risk of premature empathy and the counsellors concentrated upon creating a supportive climate in which these issues could be investigated rather than examining the issues themselves.

'Too much empathy too early in helping may have a deleterious effect upon patient development because it may create too much tension or anxiety in the helpee.' (Carkhuff and Berenson, 1977, p. 8)

In addition to the above the counsellors experienced a range of problems in this initial stage:

- 1) trying to hold in their immediate memory all the issues which the patients had raised;
- 2) if a patient raised an important issue but the group focus changed how did the counsellor return to that issue;
- 3) should the counsellor intervene in any conversations or try to change or stop what was being said;
- 4) being aware of patients vulnerability and low self-esteem;
- 5) at what point they should try to move to a greater depth to explore a patient's problem;
- 6) finding the best vocabulary to explain to the group what was happening without getting involved in counsellor jargon;
- 7) recognising when a patient felt hurt by something that had been said or they had expressed.

The one feeling that patients did express and

which seemed safe for them to explore was anger. However, it was unlikely that the counsellors could have stopped the exploration in either group. It was particularly strong in Group 1. Patients were angry that they had a chronic disease and that the medical profession had no effective treatment for it. They were angry that it had had such a dramatic effect on their lives and they were annoyed about the feelings of helplessness associated with it.

The anger was also evident in the question 'Why me?' This was a troublesome question for patients. As there was no known cause patients were frustrated about the lack of ^alogical reason as to why they should have it whilst others were disease free. The ability to attribute a cause was important and did satisfy patients. Pat commented that she "must have been a bad bairn" and whilst illogical the assertion did appear to bring comfort. The patients also found it difficult to reconcile the fact that other friends had not taken care of themselves but remained disease free.

There was much displaced anger concerning the disease and some of it was directed at the medical profession. In as much as the project had expressed a wish to help the patients so the counsellors in turn received part of this misplaced anger. It was an example of transference and one in which the counsellors could have become involved in counter transference. The problem was discussed in a research meeting and the counsellors felt confident that they would not be drawn into counter transference (Flapan and Fenchel, 1984). These concepts were psychoanalytical and are found in the Freudian literature discussed in Section 1, Chapter 3 and indicate the need for

eclecticism.

The issue of anger was evident in Group 1 where one patient had become a focus of concern. John D. was a 63 year old man who was married and had a son who lived in London and whom he never saw. He had lead an active life and had taken a pride in his employment as a machine worker. He had not suffered from any illness or physical injury. When he was 60 he started to get pain and stiffness in his feet. His GP diagnosed rheumatoid arthritis. He advised him to give up work, suggesting that this strategy would prevent the disease from getting worse. The GP explained that there was nothing that could be done for him and the best course of action was to go home and make himself as comfortable as possible.

John followed his GP's advice, gave up work and stayed at home. One of the incidental effects of this strategy was to deprive him of contact with sources with which he strongly identified. He no longer worked and the loss of his job affected him deeply. A reduced level of income imposed a restricted social life. On several occasions he commented to the group that he was sitting beside the fire waiting to die. He had apparently lost the motivation for living.

During the third session the counsellor had introduced a 'round' where patients identified and spoke about something new that they had done during the preceding week. When each patient made a contribution John interrupted them and said that what they had identified was not new. He exerted a strong influence upon the group which

was dysfunctional and disruptive at times.

At the next meeting of the research team John's position within the group became a topic of discussion. Concern was expressed because:

- 1) his negative attitude may make the group reject him and he would be further forced in upon himself;
- 2) he appeared to have identified strongly with his job as a machine operator and had found no adequate substitute;
- 3) the group's response to him was one of opposition and they ridiculed his attitude of waiting beside the fire to die;
- 4) he tried to control the group by sabotaging tactics when it tried to make progress;
- 5) his perception of his own life was that of being helpless;
- 6) he appeared to be afraid of change but the group had accepted the challenge;
- 7) he appeared to be using repression resistance to protect himself from anxiety (Collison, 1984).

The next session of the group was similar to the previous although there seemed to be more cohesiveness. The anxiety and anger of the group were still present and directed at the medical profession. John was largely responsible for this discussion. At the end of the session Alma and Margaret remained talking. Alma had decided that they should send Alex and John Valentine Cards.

At the next session Alex made a point of acknowledging the card and he was clearly delighted to have

received it. John, although prompted by Margaret, would not acknowledge receipt of his card. All of the group knew he had received the card and he tacitly admitted it by saying "pass" when Margaret asked. The rejection caused some embarrassment for the group.

John arrived early for the next session and announced to the researcher, who was setting up the video equipment, that this was the last session he was going to attend. He admitted that he was holding back in the group and in life generally. He said that he had accepted the invitation to participate in the research without discussing the matter with his wife. His wife was not very well and he thought he should stay with her. The researcher expressed regret and hoped he would reconsider his decision.

When the session started John seemed in a truculent mood and tried to sabotage the first round. He gave out non-verbal signals of detachment from the group. At an appropriate moment John said that he would not be back. Joan interpreted this remark in the context of what John had been saying earlier - that he was sitting beside the fire about to die. Joan told him she did not believe him and John made no further comment. He did not return to the topic. After this John became subdued and took no further part in the group discussion. He left at the end without further comment.

During the next session the counsellor asked for a 'round' on the topic of the loss of John. All expressed a level of affection for him and were genuinely upset that he had left. Dave was critical of him because he considered

that John's physical condition was not very bad and that he had made matters worse by giving up his job and by following his doctor's advice. The counsellor suggested that she and the researcher should both write to John. This was accepted and an offer of individual counselling was made to John and he was also assured that his place in the group would be kept open for him. The letters did not receive a reply. John was never referred to again by the group.

The next focal point for anger within the group was Dave. He was critical of his medical care. He received sodium aurothiomalate (gold) injections. He was increasingly experiencing spells of dizziness. He was not sure whether these were a consequence of the disease becoming more active, or a side effect of the gold injections. He received his injections from his GP who told him that his condition was continually being monitored through blood samples and he had no cause to worry.

Dave made periodic visits to a consultant rheumatologist. Dave told him about the spells of dizziness. The consultant advised him to come off the gold injections. He told Dave that he would write to his GP and give his opinion. The prospect of giving up gold injections was frightening for Dave because the injections had allowed him to carry on with his job. He was married and had two children. He had received gold injections for 5 years and they had removed his pain. The prospect that his medication would be stopped and that he would suffer from the pain was extremely distressing. The power that the consultant wielded by virtue of his position was considerable.

On Dave's next visit to his GP he reported the

conversation he had had with the consultant. His GP let him read the consultant's letter which made no reference to the gold injections. His GP once more told him that he was monitoring his condition. The GP appeared to be irritated by the implied suggestion of his apparent lack of competence. The episode was a source of anxiety for Dave who also experienced anger due to the sense of helplessness he felt. The contradictory advice from consultant and GP exacerbated his worry.

Dave continued to talk. He related that he had thought the research had been connected with physical activities. He thought they were to be given manual tasks to complete and that they were to be video recorded so that there was a record of the expression on their faces. It was difficult to understand how this misinterpretation had arisen. He was aware that he was to be video-recorded, but no mention of completing physical tasks had been made. Dave had received the letter outlining the aims of the research so it was difficult to imagine how he had misunderstood them.

It was the last session that Dave attended. To what extent he might have been influenced by John was not possible to estimate. He had admitted that the group had helped him. He was also aware he had been of assistance to Pat who was about to start gold injections. He gave no indication before his departure of his intention to leave. Dave appeared to have benefited from the therapeutic factors associated with group counselling identified in Section 1 of Chapter 3 and it is interesting to note that this does not

guarantee continued group membership. He too received letters from both the counsellor and the researcher offering individual counselling or a return to the group. At the next session his departure did not cause much comment from the rest of the group. They acknowledged that he had left, expressed regret but did not dwell upon his departure.

There was discussion about the aims of the group. Margaret, who was now a forceful personality, thought that they should offer support to the members outside the group meetings. This was a theme that Margaret was to return to on several occasions. She did manage to establish a support facility. It had become the practice of the group to send cards to members who missed meetings. When Margaret signed her name she also put her telephone number. This invitation was accepted by some and a social network outside the group meetings had been established. It was an example of the difficulty of controlling variables in the arena of social science research. If a scientific research design only had been used then this factor would not have been discovered and the results would have ignored its influence. The new paradigm research element was flexible and could accommodate the fact that people would behave in unpredicted ways.

The group had now verbalised a number of issues and it was suggested that a doctor should be brought in so that their questions could be answered. There was an obvious temptation to comply with this request. There was medical expertise available. and patients had expressed a great deal of concern over their medical treatment. The opportunity to discuss the matter with a doctor would have given them the chance to dissipate some of the anger that they felt. The

possibility was discussed at the research team's meeting and rejected. The reason was that it would have ignored one of the basic tenets of humanistic counselling. The theory maintained that people had the potential to solve their own problems. If they were not solving their problems then it was because their inherent potential was being blocked. One of the therapeutic values of the group counselling was the ability to unblock the persons' capacity for solving their own problems. This theory was firmly grounded in humanistic psychology as discussed in Chapter 3.

Most of the topics that members did bring up for discussion were concerned with problems outside the group and they did not focus upon the behaviour of members within the group. There was a reluctance to admit to personal problems and this reluctance to discuss immediate concerns was a feature of groups in their preliminary stages of forming (Bion, 1961).

The members of the groups appeared reluctant to admit they they could have personal problems. It was noticeable that the members who were absent were described as having problems and people expressed sympathy for them which was an example of secondary gain resistance (Collison, 1984). None of the group said that they were in need of help. The members stated that they were coping well and there were patients who were much worse than them which was another example of resistance. Being able to identify people who were worse was a common coping strategy.

Group 2 had established distinctly different norms. The atmosphere reflected those norms and the

character of the group was quieter and more subdued. It was obvious that the members of the group had withdrawn from social contacts. They had developed a stoical attitude towards their condition which had been inculcated by society. It had been noted in Chapter 2 that society in general did not like to observe the chronically sick suffering. Society prefers patients to retire and do their suffering in private and these patients had acquiesced in that process (Blaxter, 1976).

The models that explain social reactions to health are concerned only with acute diseases. It has been noted above that society can cope with people who were given the sick role and were absolved from normal responsibilities because it knows it is only for a short time and these people will return to fulfil their function (Parsons, 1952). In cases of chronic illness society was not willing to allow the sick person to have the sick role permanently. The chronically sick were expected to accept their suffering and make whatever contribution they could to society. It would seem that Group 2 were influenced by these social forces and had withdrawn from social intercourse.

For Group 2 the group meetings were a focal point in their week and Sarah commented that Tuesday was the one day she looked forward to. Dorothy said that she had not felt well at present but had made the effort to attend. None had their own transport and travelling was a source of discomfort and pain. This was an indication of the efforts they were prepared to make to attend.

The members appeared to identify with each other and this identification was established early. It was a

single sex group and none of the members worked. Group membership had clearly made a difference to them. It was noticeable that after the first two sessions the members had taken more care with their appearance. Their clothes were more colourful and several had their hair set on Tuesday morning. There was a significant change in the appearance of Ida. Her demeanour had changed as well. During the initial sessions she had sat with her head bowed and she had not maintained eye contact with anyone. By the fourth session her appearance and stature had altered. She held her head more erect, maintained steady eye contact and spoke directly to the group. At the end of the third session Maureen said how pleased she had been that Ida had spoken to the group as a whole. The remark was an indication of the caring atmosphere that had been created.

The group had a social orientation which compensated for their present lack of social contacts. Edna suggested that the group organised trips out. No doubt the social aspect compensated for the social contacts they had lost. Many had led active lives but the disease had stopped their social activities. Sarah had enjoyed dancing but had stopped when it had become too painful. Josie said that she came to the group to escape from home and to enjoy herself. The group counselling setting was clearly unusual for them and they were not sure what was the appropriate behavioural response. They seemed reluctant to ask questions or to confront the issue of why they were there. It seemed that they were grateful for the opportunity of being out. The excitement of meeting new people was an end in itself.

The group created a warm, supportive and comfortable atmosphere from this early stage. This contrasted with their passivity. The group were ready to be lead. No one showed any initiative to assume a leadership role. They had found it difficult to accept the discipline of a round and many simply passed. They did not seem to enjoy talking in pairs and had no reluctance to talk to the complete group. It was difficult to account for this phenomena. Most of the group had appeared to have had a submissive role during their life and it may have become a characteristic of their behaviour. This may have made identification easier within the group and helped to improve cohesiveness.

The reluctance to be organised should not be confused with a reluctance to disclose information about themselves. From an early point in the groups' life the members seemed quite open with each other. They appeared to freely disclose autobiographical details of their lives but they were not prepared to discuss feelings at this stage. The counsellor had explained that problems people had were often associated with how they felt about something. The explanation, although plain, did not appear to be understood. It was noticeable that Maureen seemed reluctant to approach the level of feelings. Often when one member of the group seemed to be about to disclose some intimate detail of her life Maureen would sabotage the conversation and change the subject. Whether this was consciously done in the same way that John had sabotaged group progress was difficult to estimate. Maureen did not sabotage progress for the same reason as John, although the self-disclosure may

have made her feel uncomfortable.

It seems self evident that a patient's psychological state would be important however this is not always so. Josie related that when she had been diagnosed as having rheumatoid arthritis her doctor had told her that there was nothing he could do for her. This approach upset Josie because she wanted to fight the disease. It seemed important that doctors understood their patient's psychological state and could relate their medical approach in the light of it.

SUMMARY

The groups had formed and the first stage had been successfully completed. After this point it was noticeable that the focal point of the groups had changed. The preliminary sessions with planned activities had encouraged a supportive and caring climate. The groups had experienced together the anxious moments of forming. They had come as individuals and now were beginning to form a group-as-a-whole identity. The individual group members could identify with the rest of the group when they were away from it and social links and contacts had been made. The atmosphere was relaxed and informal, friendly relationships had been formed. The groups had experienced a range of emotions including laughter, anxiety, nervousness, sadness, happiness and bereavement.

A number of issues had been identified such as boredom, shame, guilt, and lack of confidence. These topics could be explored in further sessions. The counsellors had experienced a considerable amount of personal stress. They

had felt responsible for the success of the research and knew that the initial stage was crucial. Two members had left Group 1 but it appeared to be strong. An indication of the success of the research was the fact that Alex had remained in the group. On several occasions he had referred to himself as a shy bachelor. In addition to his rheumatoid arthritis he was hard of hearing and needed the assistance of a hearing aid. This disability caused him much distress. His continued presence in the group was an act of some courage and indicated that the group had established a warm and comfortable climate that supported him.

Group 2 had also experienced a significant event which could be noted as a sign that the group had taken on its group-as-a-whole identity. The counsellor had set a group activity. Each patient was asked to describe the person sitting on their left. It was apparent from the descriptions they gave that they had an affectionate regard for each other that was genuine and sincere. The activity seemed to acknowledge and officially state what they felt about each other.

There was a temptation to try and categorise the activities of the group. This temptation would have lead to a rigid and highly structured artificial framework. An attempt to categorise the groups would be mistaken and misleading. It would not have kept the flexibility that the theoretical basis of humanistic psychology had provided.

The groups did not change simultaneously, nor were they motivated by the occurrence of the same activities or perception of similar cognitive experiences.

But it was noticeable that the focal point of discussion had changed. The ice-breaking and climate creation had taken between four to six weeks. The groups had formed and they were now ready to take control of their own development. It was noticed in Chapter 1 that rheumatoid arthritis has no known aetiology or pathogenesis. Chapter 2 provided evidence that this fact caused stress for the patients. The groups were now to focus upon that topic and members exchanged information about their condition and medical regimen.

INFORMATION EXCHANGE

The second stage was characterised by the amount of information that patients exchanged regarding their medical regimen. The groups came to understand that everybody's life had been radically affected by the disease. This contrasted with the needs of society which required them to bear up under their misfortunes, to make the best of it and not complain. The stage was therapeutic because patients realised that their need for special treatment was legitimate and society's expectation of them was unrealistic.

An optimum climate of care had been created in the previous stage and the members were secure and felt confident to take a more participative role. They focused on a topic of common concern which was their medical regimen. One feature of their medical regimen was of particular importance and that was the drugs that had been prescribed. It soon became obvious that none of the patients strictly followed the instructions that they had been given, but they adapted them in the light of their own experience (cf. Ferguson and Boyle, 1979). It was apparent that there was no standard drug response from either the GP or consultant. Patients were given one of a range of drugs or they were encouraged to do without. It was becoming obvious that the drug treatment did not meet the expectations of the patients (Platt and Dick, 1986; Capell et al., 1983).

As patients discussed their medical regimen it became evident that the instructions and advice that they had been given by their consultants and GP's was widely divergent and occasionally contradictory. One

consultant did not like to prescribe drugs but instead encouraged his patients:

- 1) to remain as active as possible;
- 2) to take reasonable exercise;
- 3) to maintain interests and hobbies;
- 4) not to submit to the temptation to give in to the disease.

Remaining active was important because rheumatoid arthritis affected joints, movement became painful and immobility became preferable to activity.

Other consultants maintained that there was a medical response to the disease. This divergence of opinion was known and accepted by the patients. One of the consultants had broadcast on local radio declaring that there were drugs to treat patients. Margaret telephoned him and arranged an appointment. He was not her normal consultant, Margaret's consultant favoured a non-drug approach to treatment but she wanted a medical response. Consultant swapping was possible in the same way that doctor swoping was possible. This divergence of expert medical opinion was not a secret but the fact that patients could transfer from one consultant to another was not generally known.

Patients were very surprised to discover that there was no medical reason why they had been started on a particular drug. When they discussed their medication one patient would relate that they had been given Naprosin. Another group member would recount that she was allergic to it or that it had no effect. Slowly as the group discussed

the range of drugs they had been prescribed it became clear that there was no discernible underlying reason for prescribing them. It occurred to the patients that the method of prescription was ad hoc and in accordance with the consultant's inclinations.

After a period of trial and error with a variety of drugs most of the patients had discovered a drug that they found effective but in many instances the drugs had begun to have side effects. The patients experienced nausea, dizziness and rigor. These feelings gave rise to the sense of being unwell and ill. This physical sensation was unpleasant and had a debilitating effect. Patients were also aware through media reports that arthritic drugs were being withdrawn from use because they were not safe (Dyer, 1987; Veitch, 1987).

In Group 1 Joan said that she was allergic to all drugs. She had had rheumatoid arthritis for the previous thirty years. For the last ten she had not been able to tolerate any drugs. She did have analgesics which she would resort to if her pain became intolerable. Joan was one of the three patients in Group 1 who was still working. The rest of the group were full of admiration for her because being allergic to all drugs she had no means of relief.

Joan related to the group her experiences and thoughts regarding her allergy. She told the group that whilst she did suffer pain she no longer experienced the side effects of the drugs. The nausea, dizziness and rigor had left and with it the sense of being ill or unwell. Whilst she undoubtedly suffered pain she did not feel ill or unwell. This situation was preferable to taking drugs. She

no longer felt the helpless victim of her medication. It was soon evident that other patients considered the potential benefit of giving up drugs.

Group 2 did not have anybody who was allergic to drugs. They seemed much more passive and did not consider giving up their drugs. In contrast they seemed to welcome and value the fact that they had something to help them. Audrey did not feel happy about taking drugs and she had reduced them to the minimum but others said that they could not exist without them.

Before the beginning of the next session the counsellor had telephoned the researcher to say that she was ill and would probably not be able to make the session. The researcher sat in as a substitute explaining that he had seen the video tapes, knew what had happened and knew what the counsellor wanted them to discuss. The group were very accommodating and did what they were asked. It was soon evident that they were not behaving with the same warmth and spontaneity when the counsellor was there and there was an atmosphere of artificiality. After quarter of an hour the counsellor appeared and the group displayed visible pleasure at seeing her. The atmosphere of artificiality continued and the researcher decided that it would be better if he left. He excused himself at the first opportune moment. The group immediately returned to the warm and caring climate that was a characteristic of it.

As a counselling issue it was becoming clear that the patients no longer felt the need for group exercises. The opportunity to talk with other patients who suffered

from the same illness was a therapeutic experience in itself. Group members were now able to consider the possibility of exploring their personality in the group context. As the exploration began it soon became deeper and the group discussion began to move towards intimate and personal matters.

As patients explored their medical treatment it became more evident that they had received much contradictory information and advice. There were instances when consultant or GP's had used medical language to obscure issues and advice they were giving. This use of medical language was clearly a source of stress for patients who could not understand what was being said or the implications of it. In common with other professions the medical professions use of a private language seeks to obscure the reality from clients. There seemed little benefit in obscuring a patient's medical condition by technical language. To use words like oedema instead of swelling only confused patients and made them feel helpless. There was an example where Doreen had gone to be assessed for a disability allowance. She had been asked to do various movements. She said, "The doctors talked to each other in their own language." This use of medical language was a source of stress for patients.

From the comments made in the groups it became clear that the patients believed that the GP's and consultants were there to treat their illness. They did not believe that their GP or consultant saw them as people. The groups accepted that the focal point for the medical profession was their medical complaint and as people they

were a secondary concern. This emphasis upon the medical aspect meant that when the GP's or consultants diagnosed an illness they felt obliged to prescribe a course of treatment irrespective of whether or not they could cure the patient (Jennett, 1986). This situation was communicated to the patient who knew that they would interpret the doctor's decisions, information and advice. If the doctor told a patient that there was nothing wrong then the information carried two messages for the patient:

- 1) there was nothing wrong;
- 2) it was so bad he would not tell.

An example was given by Doreen whose consultant had told her her knees were not bad enough to be considered for replacement. This information carried two messages for her:

- 1) my knees were alright;
- 2) my knees were so bad they cannot give me replacements.

The use of medical language to give a scientific explanation to decisions which were inevitably valued laden obscured the GP's or consultant's personal values. It was evident from the experiences that the groups recounted that the medical profession responded to rheumatoid arthritis in accordance with their personal values. This was clearly demonstrated in the example of Invalidity Allowance.

To be considered for Invalidity Allowance patients had to be examined by a doctor and a report written. Patients experienced a wide range of responses. Helen was treated with great respect and sympathy by the doctor she was examined by. His examination was cursory. The doctor

commented that rheumatoid arthritis was a dreadful disease and he had every sympathy with the patients. He showed her the questions on the report form and also his answers. Helen soon heard that she had been granted Invalidity Allowance. Helen worked as a warden of a Old People's Home at the time. She had only been diagnosed as suffering from the disease for one year. She was active and well compared to some of the other patients.

The group compared Helen's experience with Alma's. She had had rheumatoid arthritis for ten years. The GP who examined her watched her walk up the steps to the surgery for the appointment as part of the examination. The group judged this to be underhand. Alma had great difficulty in moving and she wanted a Invalidity Allowance so that she could get a disabled car sticker so that her husband could take her into town and wait while she went into a shop. The doctor was matter-of-fact in his examination showing little of the care or consideration that Helen received. She was advised later by letter that she had not satisfied the requirements.

The difference between the two experiences annoyed and upset the group. There was an obvious disparity between the cases. The different decisions may well have been a result of the way in which the GP's interpreted the disease. This may be a consequence of the imprecision of rheumatoid arthritis as a concept, as discussed in Chapter 1, leaving decisions to be affected by the GP's personal values. These differences were an unnecessary source of stress and anxiety for patients.

The patients medical experiences contributed to

the information that was exchanged. The groups concluded that there was no standard medical response to the disease or their treatment. From this confused situation some of the patients claimed that they had their own remedies. These remedies, they asserted, were just as effective. The group members began to believe that it was possible that their actions could relieve their symptoms and improve their condition. This understanding brought the instillation of hope, which itself was known to have a therapeutic effect (Bloch and Crouch, 1925).

Through the exchange of information the groups began to discuss different coping strategies. These included an interest in diet, herbal remedies, exercise, taking responsibility for their own health, rest and warmth. The groups began to bring in booklets and newspaper cuttings about these coping strategies.

Diet was a frequent choice. Some of the members were already following a prescribed diet and this principally excluded red meat. Patients found it simple to experiment with their diet and many new dishes were tried. Doreen was told about cider vinegar and honey. She purchased the ingredients and tried for two weeks but reported that it made no difference. She was left with a jar of cider vinegar and a jar of honey. The cider vinegar was poured down the sink but the honey seemed too precious to waste. She started to put a teaspoonful into a cup of tea each day. After two weeks she noticed a difference in her condition and reported that she felt better. This small initiative on her part had a remarkable effect upon her. She found that there was

something she could do to improve her medical condition. Her sense of helplessness lessened and she took some responsibility for her health once again.

It would appear that people such as Doreen had given up responsibility for her health. It could be argued that the medical profession had colluded in this process. It would seem that a distinction should be made between acute and chronic illnesses. In cases of acute illness the GP could retain responsibility because he could effect a cure. In cases of chronic illness no cure was available and it was important that patients should feel responsible of their own health. One of the consultants was trying to encourage patients to take responsibility for their condition but his reasons were not properly understood and some patients attributed it to a lack of care.

Herbal remedies were associated closely with diet. Although they were talked about nobody actually regularly tried them. One patient had tried Radiol B. This was used for rubbing into the joints and was based upon a horse lineament. The patient attested to its effectiveness. Unfortunately it had a terrible smell which irritated his spouse's chest so much that he was hospitalised.

It was recognised by most patients that exercise was an important contributory factor to facing the challenge of coping with rheumatoid arthritis. The need for exercise was a correlate of disease activity. If patients were experiencing a period of exacerbation then exercise should be restricted or curtailed. It was felt that patients were in the best position to know exactly what was sensible under the circumstances.

The variable nature of the disease was a source of stress with other family members. Some patients did not know how the disease was going to affect them on a daily basis and could only make decisions about what they were capable of doing when they woke up in the morning. In these circumstances the roles and duties of each family member had to be re-negotiated each day.

This process placed considerable strain upon the relationships because they tended to vary each day. Planning family activities became impossible. In some cases each day was taken as it came. This variability made it difficult for family members to get the balance correct between doing too much for the patient and not enough. The temptation was invariably to help the patient too much. This came from an impulse to show sympathy, also because it was often quicker. Certain tasks got done much quicker if one of the family members did them.

Both the patient and the family members had to cope with increased levels of stress. The patients because they could not do things for themselves or others. They also had to accept the standard to which other people worked. Minor household activities could become major sources of aggravation. One patient had to cope with her irritation whilst watching her husband wash the windows to a standard below hers.

Family members had to watch whilst the patient painfully struggled to complete a simple task that they could have done easily and perhaps were waiting for. If it had been possible to negotiate a compromised position then

both parties could have coped better. The problem was that the situation was changing daily. One day a patient could complain that they were expected to manage without help. The next day they would complain that the family was trying to make them into an invalid.

Patients were also aware that they had to take responsibility for themselves. This was the beginning of a theme that was to become more important and will be developed in the rest of this chapter. Margaret who was a nurse was particularly concerned with this attitude. Before contracting rheumatoid arthritis she had nursed patients and she had thought she had appreciated what it was like to have the disease. She now reported that she had not imagined that it was as bad as she discovered. This appreciation made her realise that the only person who could understand was the person. This perception made her claim that the only person who could take responsibility was the person themselves.

The final coping strategy the groups identified was rest and warmth. This strategy forced the patients to acknowledge to themselves that certain activities were *beyond them and they had to rest and make themselves* comfortable. This was a complicated area and it was not easy to untangle the causes of actions. Resting often meant bending joints into comfortable positions which made it difficult to straighten again. The foetal-like position seemed to be the most comfortable. It was easy for patients to lose mobility, and once lost difficult to regain. The converse of this position was patients who ascribed everything that happened to them to the illness. Joan

complained that the disease was responsible for making her tired in the evenings. She was a 55 year old women who worked during the day. Inevitably some of the condition was due to the ageing process yet she did not seem to be prepared to take this into account.

The counsellors were very cautious during this stage. The groups had successfully overcome the stress of forming but they needed time to cohere. It would have been unwise of the counsellors to try and identify too closely with the patients. It was in any case difficult to empathise with people who had a chronic disease and were in constant pain.

It seemed that people who were not ill had mental defence mechanisms that protected them against recognising the fact that patients were in constant pain. Society sympathised with people who were in pain but expected something to be done about it. Society did not like to watch people suffering. It has already been noted that society requires patients to suffer in private. It appears that people only sympathise whilst they think something can be done about it.

The counsellors could not empathise too soon. Too much empathy too early could have had a deleterious effect (Carkhuff, 1969). It was the final level of empathic understanding and not the initial level that was the correlate of therapeutic outcomes (Cartwright and Learner, 1969). The patients had identified a number of issues and the counsellors main role at this stage was to reflect those statements back to the group.

In Group 2 one patient Sarah had made significant changes to her life. Since starting the group counselling she had quickly realised that she had withdrawn from the social contacts. She had ceased to go out and had become isolated. The support of the group had reversed that process. She had gone dancing. It had been a hobby that she had given up. The first time she went back she sat and watched the dancing and re-established links with her friends again. On subsequent occasions she danced. She found the dancing painful and was stiff the following morning but she had determined to continue.

The next session Sarah was able to report that she had received a Valentine Card from an anonymous source. The counsellor noticed the correlation between something interesting happening in their lives and their emotional state. Incidents such as the Valentine Card had a direct effect upon the whole group. It was an example of normal events taking place in their lives and a reminder that they were normal and not chronically ill. Hope of normality was a therapeutic factor (Bloch and Crouch, 1985).

Sarah disclosed some of the details of her life including the treatment she had received from her GP. Her consultant had told her that she should swim but the swimming baths were at the other end of the town. Sarah was a widow and lived on a pension and she could not afford the bus fares. She was advised to get a bus pass. She went to see her GP to get a letter acknowledging that she needed a bus pass. It was not an easy situation for Sarah who disliked asking for free allowances. She made an appointment to see her GP and related the problem. The GP told her that

bus passes were for people who were really ill and Sarah did not come into that category. Without comment Sarah accepted the judgement and left.

Her tale caused great annoyance to the rest of the group who thought that she had been badly treated. Sarah admitted to a lack of confidence and said that she could not argue with the doctor. Josie and Audrey both said that they would not let a doctor talk to them like that. Josie told Sarah what she would have said, but the others acknowledged that Josie was different from Sarah.

It was the first occasion when the group had experienced an unpleasant incident that had become an issue for them all. They were forced to consider how they would have behaved in that situation and why the situation should have arisen at all. The fact that they were perceived as something less than normal was upsetting. Josie remarked that she had found the session a worrying one. The group seemed to enjoy the sessions most when they were lighthearted and happy. For some of the group it was the only time they got out during the week and something that they wanted to look forward to and enjoy.

Josie had always encouraged the group to be optimistic. She had been content to keep the conversation limited to superficial everyday problems. Josie then announced to the counsellor that she had to go into hospital and told her she had other medical problems besides rheumatoid arthritis. She had had both breasts removed and now had to have a lump removed from her arm. She had a very positive and determined outlook and was very contained.

Josie appeared to ignore her actual medical condition and refused to confront her problems. It seems that her coping strategy was the use of denial.

It slowly became apparent that Sarah was utilising much of the group's time. This was not a selfish act on Sarah's part but something that the group were colluding in. It was an example of secondary or epinosic gain resistance which was a concept from psychoanalysis (Collison, 1984). This topic was discussed in Chapter 3. The rest of the group were using Sarah as an excuse for not facing up to the challenge that the group counselling was offering. Some no doubt had difficulty in verbalising personal autobiographical experiences or relationships with others (Brautigm and Ruppell, 1977). They were taking positive rewards from Sarah's achievements without making any effort on their own part. The problem for the counsellor was to remove the group focus from Sarah and return the issue to everybody in the group. Fortunately Sarah felt that she had sufficient group exposure at present and was quite happy to sit and listen to others.

The group was being very positive but as Josie's case had illustrated they were not acknowledging their own problems. A norm was being established within the group that you had to fight and not give in, you had to be determined and you had to remain cheerful. The counsellor was wondering how to alter this norm when Dorothy introduced the topic of depression. She said that she frequently became depressed and thought that it was caused by the disease. It seemed that the sense of helplessness that the patients felt may have been a casual agent of the depression. The

depression may have been an anticipatory lowering of expectation in order to prepare Dorothy for some anticipated event in the future. It was useful material for the group to focus on.

Dorothy was missing from the next session and the counsellor learned before the following session that her husband had died. He had been taken into hospital with a heart attack. Dorothy was to comment during a later session that she had no idea her husband was about to die so the depression may not have been related to her husband's condition. She told the counsellor that she would like to continue coming to the group but would appreciate if the group did not express sympathy and would let her sit quietly and listen.

Group 1 were still content to discuss behaviour. The focus on behaviour prevented the group from discussing feelings. Humanistic psychology emphasised that it was feelings that were the important component in determining challenge. The counsellor reflected back to the group asking for the feeling concomitants of behaviour. The group seem to find this difficult to cope with. Feeling in a medical context was associated with physical feeling rather than emotional feelings. Patients have been told that they had a chronic disease about which they could do nothing. There was an attitude of resignation which had been inculcated with patients and to suddenly get them to explore the feeling surrounded their disease was not normal for them.

The counsellor had to reflect back to the group what it was focusing upon. There was a danger that the

counsellor might start to censor material too much by only reflecting back to the group material concerned with feelings. By this time the momentum had to come from the group and it was not up to the counsellor to manufacture exercises for the group to do. The counselling challenge was to stay with the group to reflect back their concerns, to be supportive and to offer unconditional positive regard which was one of the principles of humanistic psychology mentioned in Chapter 3.

In Group 1 Margaret was dominating the group. She was using her job as a nurse to establish a role of authority within the group. Many of the questions that the group were asking she was answering. It seemed that many of the issues that the group were slowly coming to confront Margaret had already sorted out for herself. She was trying to move the group on before they were ready. She may have intimidated the rest of the group and some had not spoken very much.

Margaret had asked when the group were going to get down to the 'nitty-gritty', although this phrase was never defined it did seem that Margaret did mean personal details. The rest of the group looked uneasy. Margaret was moving at a speed that the rest of the group were unprepared for. Agnes said that she was only there to help the researchers and would get nothing out of it herself. Pat said that she did not think she would get anything out of the counselling but having said that she would come she fully intended to keep the commitment.

The members had not identified that the group could be a source of emotional support for each other. In

many respects the group was filled by strong characters who wanted to lead but were unsure of the direction in which the group wanted to go. The counsellor allowed the group to determine its own agenda. The counsellor hoped that the group would come to understand what counselling entailed through something that happened in the group and that they could illustrate.

Margaret had continued her social contacts outside the group. Agnes, Alma and Margaret telephoned each other during the week. This trio had formed close links and there was the danger that it became a splinter group, or sabotaged the main group. It was another example of the inability of social scientists to restrict and control the variables in the research arena.

It was difficult to interpret non-verbal behaviour. Margaret often appeared to adopt a dominating presence. She would sit with her arms folded as if judging. Later she was to say that she was conscious about the deformity in her hands and she always felt that she needed to hide them. Generally non-verbal behaviour was difficult to interpret. It was mentioned above that patients found the foetal position comfortable although sitting in this position was not practical. It was possible that the non-verbal signals that patients unconsciously gave out were interpreted as 'leave-me-alone'. It was possible that patients suffered isolation because their non-verbal signals meant they wanted to be alone. Isolation could also have arisen from practical reasons. Falling was a fear that many of the group experienced. Their fear was not just pain and

physical injury but the fear that they may not be able to get back onto their feet. They were reluctant to go out during the winter or on windy days. It was a good example of the experiences that can only be understood by talking. Normal people would tend to impute normal reasons for behaviour, such as they did not want to go out.

At the next session Margaret was missing and Agnes was able to relate that she was having her teeth extracted and would be missing for a few sessions. It was noticeable that the session was more relaxed and the group used the word as a characteristic of what they enjoyed about it. Joan had talked about rheumatoid arthritis being a stressful disease and that they came to the group to get 'unstressed'. Agnes mentioned that she noticed changes within herself and the rest of the group said that their attitude towards medication had changed. They felt a much more positive attitude towards being in control of their own lives. There appeared to be much less anxiety regarding their treatment.

SUMMARY

Although the groups were very different they were following the same pattern of development. This stage seemed to have been characterised by information exchange, a process that allowed the groups to develop onto the next stage and it was the basis upon which the final stage was based. This stage also witnessed that the patients were beginning to find support from each other and it was the basis from which they could cope with the challenge of living with a chronic disease.

The groups did not seem to have accepted that part

of their function was to help each other with aspects of their lives they found difficulty with and that together they could help each other with problems. Their perception of being in the group was to talk about rheumatoid arthritis.

Humanistic theory implied that it was feelings that determine who we were and how we felt. For many of these patients their identity seemed to come from what they did. From the interactions within the groups when someone did identify a feeling the natural inclination of the group was to discover what had caused that feeling. The feeling had invariably been caused by a practical problem, usually the frustration of not being able to do something. This would cause somebody else to identify another practical problem. The focus for discussion was invariably practical problems. This process of going from feelings to a practical problem was almost the reverse of what Rogers maintained.

The disease created stress because the patients identity was continually changing. Their life was one of constant redefinition and negotiation. Their identity as wife, husband, friend, employee or mother was never stable.

SELF-DISCLOSURE

The transition from the information exchange stage to the self-disclosure stage was gradual and hesitant. The stages were identified by the research team but they did not represent rigid, discrete steps along a path of linear development, rather they were interrelated and interdependent. Because there was a vagueness about the commencement and termination of each stage they were not presented as part of a structured framework. They were mentioned because they could be identified and they did form useful concepts upon which further research may be based or theories hypothesised.

The groups had been meeting for approximately three months. The members were comfortable in each other's company and the atmosphere continued to be relaxed and congenial. A caring climate had been created and members had genuine warmth and affection for each other. The optimum levels of trust, confidence, intimacy and cohesiveness permitted further developments. These facilitative characteristics of the groups allowed them to explore parts of their personality where they felt more vulnerable. The members felt they could be more open and disclose more intimate details of their lives. This confidence had developed from the groups' experiences and they felt encouraged to progress further.

The groups were used with a varying number of members being present. During the first stage attendance had been full and regular and the group had taken on its group-as-a-whole identity. During the second stage they had become used to individual members missing occasional sessions.

These absences did not seem to affect group identity and the patients accepted them as being a normal consequence of having rheumatoid arthritis.

No one managed to attend every session. It was accepted as one of the norms of the groups that attendance would vary. The exacerbations and remissions which are a characteristic of rheumatoid arthritis interfere with patient's lives in a capricious way. The group members were sympathetic of absences. The practice of sending cards became established and this appeared to be an efficient and useful way of maintaining group identity.

The point in the groups' life had been reached when, through emotional involvement, patients were able to express very personal thoughts, opinions and feelings. Some of these thoughts had previously been unverballed or they were subconscious and not readily available to them in consciousness (Brautigm and Ruppel, 1977). The process of personal exploration allowed some members to develop new insights into their lives. These developments depended upon the emotional climate within the group being supportive, understanding and confidential. The process of self-disclosure at this point was the description of feelings that had occurred outside the groups. The groups were still not ready to explore the feelings that existed amongst members during group counselling sessions but they did hint at the feelings they had for individual group members.

When the groups moved to a new stage it was sometimes facilitative to ask them to work in the intimacy of pairs. Group 1 had been asked to work in this way, to

discuss an aspect of their life that they were not happy about. After allowing sufficient time for the activity in pairs the group was brought together and the counsellor asked if anyone was prepared to disclose to the group what they had been talking about. Alma volunteered.

Alma referred to her unhappiness as 'her tragedy'. She had already disclosed to the group that her daughter was mentally handicapped. Alma was becoming increasingly aware of her age and realized that she would not always be able to provide for her daughter. Recently she had been trying to make her daughter aware of the fact and had encouraged her to be more independent. Alma had tried to enlist the help of the Social Services Department but they were not prepared to provide assistance. The research team wondered whether Alma was complaining that her rheumatoid arthritis was getting worse as a strategy to force the Social Services to make some provision for her daughter. Whilst her daughter was part of the 'tragedy' her relationship with her husband was also involved. Alma had been separated from her husband for a period and they had only recently started living together again. She complained that her husband was a bad tempered man who did little around the house. He did not sympathise with Alma's position of looking after a mentally handicapped daughter whilst suffering from rheumatoid arthritis.

Alma disclosed a lot of the intimate details of their life together. She gave evidence of the way in which she struggled to do ordinary household activities without any assistance. She had tried to get help from the Social Services Department and she had applied for an Invalidity Allowance but had been refused. Alma represented an example

of the unequal provision of social assistance. She was clearly disabled and yet could not persuade the social agencies of the fact. She needed her house to be adapted for her.

In common with many patients who suffered from rheumatoid arthritis nocturnal waking plagued Alma. She would wake, then realise she needed to get to the toilet. The toilet was downstairs and Alma could not manage the stairs. As a consequence a large bucket was put into the bedroom with a piece of wood across it. She made do with this improvised toilet. She was a large woman and would occasionally over balance, knocking over the bucket, spilling the contents on the floor. The rest of the group were genuinely annoyed about the way in which she had been treated. The group urged Alma to reapply and advised her that she was entitled to financial assistance, to domestic help and to have her house adapted.

The research team discussed Alma's disclosures at their next meeting. They were aware that Alma's daughter was twenty six years old. From some of the incidents Alma had related it appeared that she was over protective of her daughter. Her daughter appeared to fall into the category of not being severe enough for institutionalised care. It seemed to suit Alma's purpose to have her daughter around and the team conjectured that subconsciously Alma might be using her as part of a coping strategy. Alma's mother and sister would not help in any way and this had tended to increase Alma's bitterness.

The research team also discussed the extent to

which rheumatoid arthritis could be used by patients to gain control over their environment. It had been observed that in married couples there were no cases ~~were~~ both partners had the disease. Rheumatoid arthritis would be an effective measure for manipulating marital relationships. If patients were in a period of remission the partner was unlikely to upset them in case the disease became more active. If they were experiencing a 'flare' then the spouse would have to look after them.

Rheumatoid arthritis was an atypical disease because it combined characteristic of both chronic and acute illness. This feature increased the manipulative ability of the illness. It was argued in Chapter 2 that whilst society could cope with its acutely sick it could not cope with its chronically sick. The chronically sick were expected to carry on with their lives and make the best contribution to society that they could. Because rheumatoid arthritis was subject to periods of exacerbation it had the same effect as an acute illness. Patients had to be nursed because they were capable of physically improving.

The research team were interested in the fact that rheumatoid arthritis affected women to men in the ratio of 3 : 1. It was now recognised that this relationship only applies to the 40 - 60 age band and for other ages the incidence of the disease was 50 : 50 (Anderson et al., 1985). The team were also aware that pregnant women often lost the symptoms of the disease during pregnancy. The hypothesis that the disease was affected by hormonal imbalance associated with pregnancy and menopause was suggested. This may be an fruitful line of inquiry.

It was noticeable at this developmental stage that the traditional function of the group counsellor changed. There was little need for activities that encouraged group interaction. Individual members disclosed important events in their lives to a silent but attentive audience. The fact that they recounted the details was evidence that a great deal of trust and confidence existed. The counsellors found that they were largely redundant during the sessions. The members were eager to disclose autobiographical incidents and any intervention on the counsellors' part would have demeaned the individual member.

Rita spoke at some length. She had been a quiet but keen observer of the group. In some respects she was at variance with the rest of the group because she was satisfied with the treatment and medication her consultant provided. She had recently moved into the area and seemed to find the different cultural patterns unusual. Her degree of disease activity was severe. She could only walk with the aid of sticks and a supporting arm otherwise she had to use a wheelchair.

Rita was married and she had two children. The eldest was a daughter. When her disease had started her daughter seemed sympathetic and considerate. As the disease activity had got worse she found that her daughter had become less concerned. Rita believed that her daughter could not cope with the fact that her mother had a debilitating disease and could not cope with watching her mother become deformed. Her daughter stopped calling and Rita rarely saw her. It was an example of the way in which the disease can

cause the deterioration of loving and firmly established relationships.

Alex participated more frequently within the group. He was the only male member and a bachelor. The group meeting was a significant event in his week. He commented that after the sessions he could not sleep at night and his mind was in 'a whirl'. The lack of normal social intercourse could have far reaching consequences for Alex. It was noticeable that he seemed to treat the female members as stereotyped characters, however, he was moving away from this rigid perception and he treated them more as individuals. Alex was becoming more aware of his strengths and weaknesses and in addition he explored his own personality to greater depth.

It was important for patients that they could establish strategies that helped them cope with the disease. This was very much an individual process and what worked for one would not work for others. The same fact could be interpreted in different ways. Maureen complained that she was beginning to get a ringing sound in her ears. She was anxious to discover whether anybody else experienced it. One other member commented that they had the same thing and that it was associated with rheumatoid arthritis. This was a source of relief for Maureen as her coping strategy was that she was not getting another illness.

In another example Joan was able to tell Margaret that her new symptom was not associated with rheumatoid arthritis. Margaret felt relief because she was worried that the disease was getting worse. She could cope better with the fact that the symptom was associated with a new disease.

These coping strategies were important for patients and if GP's and consultants were aware of them the standard of communication and adherence to their medical regimen might improve.

Group 2 felt that society did not understand the feelings of people with a chronic illness. Too often they expected them to join in activities when they were not physically capable. It was felt by the group that society should be educated about how patients felt so that they would stop putting pressure on them. The plea was associated with the fact that society did not wish the chronically sick to be given special privileges. It expected them to engage in all normal activities.

Group 2 had always claimed a strong social orientation for the aims of their group counselling sessions. They saw the counselling against that background. Before the group counselling sessions they met in the foyer of the New Medical Block and exchanged greetings. They all depended upon public transport or Dial-a-Ride. Often they would arrive half hour before the counselling session was due to start, occasionally some would arrive one hour before. They bore the vagaries of the public transport system with fortitude. Much information was exchanged during this period and it was an important loss to the project.

The same procedure occurred at the end. The group would return to the foyer, some would leave immediately but others had to wait for transport. Discussions commenced during the counselling session were continued during this period. It was evident that there was

no change in focus or climate between the counselling sessions and these introductory or leaving periods. Patients did not therefore see the counselling as something different. These periods were not shared by Group 1. All of this group were brought either by car or taxi. New paradigm research methodology seeks to incorporate this finding into the results and can accommodate the fact much easier than scientific research methodology.

The group counselling for this set of patients could not start from the same premise as more traditional encounter group counselling, which was discussed in Chapter 3. The members of both groups did not feel that there was a need to change their behaviour. This contrasted with other groups that had accepted the need for change or the wish to develop an aspect of their personality which was under-utilised or dormant. The two groups had not been told that their behaviour had altered and that they needed to change. There was no motivation for this group of patients to change in that way. The groups were happy to sit and talk because they thought that was what was expected of them. They had had the disease for a number of years and had developed their own coping strategies which may have been subconscious. The members of the groups needed reassurance and reinforcement that their coping strategies were adequate and that they did not need to change. Changes in the groups were therefore slow, tentative, cautious and hesitant.

During this stage Pat disclosed much of her medical history. She had had many complaints and they had lasted for some considerable time. She had had rheumatoid arthritis as an adolescent and it had been getting

progressively worse. In searching for aetiological causes she said that she must have been 'a real bad bairn'. She did not attach any truth to this statement but verbalising it seemed to give some comfort. Pat was 29 years old and the youngest member. She was about to go onto gold injections and was very anxious that they should provide an improvement in her medical condition. She gained a measure of support from the rest of the group who were clearly in sympathy with someone who had had the disease before they could have satisfied normal ambitions such as raising a family.

Pat recounted other aspects of her medical history. She did not just suffer from rheumatoid arthritis. On returning from holiday in 1984 she had had severe diarrhoea. The diarrhoea had persisted and she had consulted her GP who had referred her to a consultant. Ulcerative colitis was diagnosed and it was recommended that she had an operation to remove some of her bowel and have a drain inserted to see if the diarrhoea cleared up. She had the operation but the problem persisted. She had another operation and her lower bowel was removed and a side opening created. The medical aspects of the ileostomy were successful but it left Pat to cope with considerable psychological adjustment. She was married and had to explain to her husband the implications of the operation. Her husband appeared to be very supportive. They were left to cope with the bags and the smell.

There were no details of Pat's ileostomy in her file. The rheumatology consultant who referred her to the

researcher never mentioned the complication and she had been admitted to the study. Pat had many areas of concern about her future. She worked as a secretary and found that on some days the job left her feeling exhausted. She was worried as to how much longer she could continue. Whilst she was not making medical progress she felt that the other aspects of her life would have to wait. Pat appeared to have a satisfactory relationship with her husband who had known that she had rheumatoid arthritis before they had got married. He supported her and helped with household tasks. Pat's parents lived in close proximity. She had a satisfactory relationship with her parents and could rely upon their support.

Pat had been open and frank with the group. She had been nervous when she had started speaking but her nervousness disappeared when she became aware that she had the sympathy and interest of the group. The group clearly warmed to Pat whilst she was talking. They were full of admiration for her and they had been interested in the account of her ileostomy which was outside the range of their normal medical experience.

Pat had an innocence and sincerity that engendered affection. She was the youngest in the group and her optimism was a quality that the rest no longer demonstrated. She was a role model for the group and they began to talk with the same enthusiasm and sanguinity.

It has been noted above that the medical records of patients were not always accurate. If a patient attended two different hospitals they each kept their own set of notes. Sometimes the results of tests were not included and other

relevant information was missing. In addition, the GP's notes would need to be taken into account to get an accurate overview of a patient's medical history.

As the research progressed it became obvious that a number of patients had other problems, some serious. Margaret had haemophilia, Joan had had cancer, Josie had a range of complaints. There were also minor complaints which may have been iatrogenic. No doubt the anaemia associated with blood loss from non-steroidal anti-inflammatory drugs contributed to the medical condition of patients.

The longer the research progressed the more blurred became the exact medical condition of patients. The research team perceived them as individuals with health problems rather than patients suffering from rheumatoid arthritis and this latter description carried little meaning. The scientific research methodology might appear to have accuracy because the information the researchers elicit from patients was restricted. The relationship between the patient and their state of health was extremely complex. It may well be that the scientific approach of identifying individual variables and investigating them was unrealistic and the complete picture was much more complicated than imagined. There were medical aspects of the patients lives that the researchers had not been aware of and which were not examined or held constant.

Eight weeks after the commencement of the project Group 2 experienced a sudden shock. Jenny's husband had died unexpectedly. Jenny had been a popular member of the group who had been keen to support everybody else. She had been a

major influence within the group and was partly responsible for the caring and compassionate climate that characterised the group. She was warm and affectionate and rewarded other members whenever possible. The death of Jenny's husband had been the second that the group had experienced in a relatively short space of time.

The counsellor told the group of Jenny's bereavement. Jenny had said that she hoped to return the following week as she had found much benefit in belonging to the group. Inevitably the group were somewhat subdued and in a reflective mood. In the middle of the session there was a lull in the conversation. It was the first period of silence that the group had not felt uncomfortable about. The counsellor sensed that their thoughts were of Jenny so she legitimised the silence by asking that they sat and thought for a few moments about Jenny and her loss. This period of silence was held until the counsellor broke it. Previously the silence had been broken by Maureen who had not felt comfortable with anything that concentrated upon feelings. The silence had a therapeutic effect on the group and it was a significant maturational point.

After the silence Josie responded for the first time at a feeling level and admitted to having to ask for help. She also acknowledged in the group that it was necessary for her to get rid of feelings. Josie felt that she was getting a better understanding of herself and her illness and the insight was helping her. Maureen expressed concern at the seeming lack of sympathy for Dorothy during the previous week which had been her first back in the group since her husband's death. Dorothy reassured Maureen that

the absence of comment had been the best thing for her. The counsellor told Dorothy that she could talk to the group at any time about her bereavement and that it would help her to cope with the emotional feelings surrounding the issue.

The session had been a useful one. Maureen commented at the end that she had started with a feeling of depression but had ended the session in laughter. Maureen had blamed her depression on the oxygen chamber. Maureen recounted that she had been approached by her consultant and asked if she would take part in an experiment. She was to have a number of sessions sitting in an oxygen chamber to see if it made a difference to her medical condition. Ch had agreed and sat in the chamber for one hour, twice a week. It had not been a pleasant experience for her.

At the end of six weeks Maureen's experience of the oxygen chamber came to an end. She was asked how she felt about it by the consultant. At that time she had actually felt better but told the consultant that the oxygen had made no difference. Maureen attributed 'feeling better' to the group counselling. In which case she had not attributed the improvement to the effects of the oxygen chamber. It was an interesting example of attribution and the way in which some pieces of medical research may have been inaccurately judged due to the patients' phenomenological assessments. Maureen's conclusions were an interesting example of loyalty. She felt loyalty to the group and it was an indication of the effect the group counselling was having.

Maureen's experience also raised the issue of

scientific research and the need to control variables. It was interesting that Maureen was allowed to take part in another piece of research whilst participating in the group counselling. It might have been an omission that the matter was overlooked. It might also have been the case that the group counselling was not perceived by the consultant as a worthwhile piece of research.

The first comment relating to feelings occurring within the group counselling session was made at this stage. Sarah initiated the comment. She was able to disclose to the group that she recognised when she began to feel uncomfortable as the focal point of the group. She was now able to take control and change the subject directing the focus away from herself. Sarah commented that she felt the group had not 'opened up' very much. The research team thought that Sarah may have misjudged the pace at which the group were willing to move or that she misjudged the value of other member's self-disclosure.

Sarah had taken the initiative in self-disclosing. She might have felt that it had been premature and resented the fact that others had not followed. Premature self-disclosure in other groups had isolated members in the group experience and they had had no alternative but to leave (Silver et al., 1982). Sarah had not self-disclosed to that degree but she was self-conscious of what she had revealed. The rest of the group had encouraged her self-disclosure so Sarah had not felt isolated or threatened.

During the middle of the self-disclosure stage Rita related an incident that had occurred at her church. Rita had always been restrained but when she had had a

contribution to make she had made it forcefully. Her husband brought her each week and she was supported at home by him and her son. Her disease had become more progressive and she had been confined to a wheelchair. However, when she went out for short journeys her stick and a supporting arm were sufficient support. She appeared to be a sensible and sensitive woman.

Rita related that she had been to her church at the weekend. There had been a special anniversary in the church's history. After a weekend of celebrations the final service was held on Sunday evening. The service was conducted by a team of visitors from London, one of whom was a faith healer. It was announced during the service that if anyone wanted to take part in a faith healing as part of the worship they should remain behind at the end of the service. Rita waited at the end and she was invited to go down to the front of the church where a prayer was said over her. She recounted that whilst the prayer was being said she could feel the pain drain away from her body. Since then she had been pain free.

The group listened attentively and were delighted for Rita if somewhat sceptical. None of the rest were to try it. Rita remained pain free for the rest of the project and her stiffness began to ease as well. Such an incident sits uneasily within a scientific designed research project. The facts of the incident could not be disputed and Rita was to remain pain free. The experience could not be controlled for, nor could the incident have been anticipated. If a purely scientific research design had been followed the

incident might well not have come to light. It was only because the group processes were investigated that Rita's experience came to light. The validity of the scientific research design was called to question, perhaps it was so successful because it studiously ignored all the data with which it had no means of coping.

During the same session Alex self-disclosed a lot of autobiographical information. He explained that he had been in pain for the last 16 years and had had found no lasting relief. He was a formal and punctilious gentleman who spoke with thought and attention to detail. He was well respected by the group and occupied an affectionate place in their consciousness and he had become much closer to them. He appeared to be more sensitive to other peoples' emotions and seemed to have a new understanding and insight of their problems.

Alex recounted how the disease had started sixteen years ago and he gave details of its progression. He had been working as a postman in Scotland and his condition became so bad he was forced to give up his job. He lived with his brother and sister and they hoped to return to Scotland once they had all retired. At the moment he considered that he lived the life of a recluse. He told of an incident which had occurred whilst he was in the Services. The incident could have led to imprisonment if he had been found out. His ordeal had left him shaking and confused.

Alex had started a diet after the information stage and he had noticed an improvement in his physical condition. In addition he was in less pain. He found that

the discipline of keeping to the diet was too strict and he had been indulging in red meat. The imposition of a rigid and strict diet could be followed for just so long then there appeared to be an irresistible urge to break the restrictions whether or not they were self-imposed. The motivation appeared to stem from a person's need to re-assert their individuality.

Group 1 had noticeably changed by this point of time. All of the group seemed to be prepared to do something to help themselves. They had moved from a state of helplessness and were more constructive. The group was more cohesive and the group's identity affected how they thought and behaved whilst they were away from the group. A feeling of confidence had started to appear and there was more laughter and happiness in the group.

Group 2 had also developed. The group members were more active and gave evidence of initiating activities on their own behalf. Doreen had re-established links with former friends. Previously she had felt that she held her able-bodied friends back. She had recently moved to a purpose-built bungalow for disabled people. Her bungalow was next to the community centre and there was no shortage of acquaintances. Unfortunately the majority were physically handicapped. Doreen preferred to make contact with her old friends and they called to take her out. She went back to the working mens' club where she had worked as a bar maid before having to give her job up, a job she had thoroughly enjoyed. She was welcomed by her old friends. They did make allowances for her but she found she could accept them

without feeling uncomfortable.

Doreen had been unable to make use of Dial-a-Ride because she lived outside the administrative area. The researcher had found that there was a small voluntary group in her area and arranged for her to be taken to the New Medical Centre. Unfortunately this arrangement did not always work and Doreen was not always picked up. On those occasions she ordered a taxi which she paid for herself so that she could attend the group. The taxi fare was considerable and it was an indication of the benefit Doreen felt she had received from the group. This benefit contrasted with the community centre next door which although popular did not satisfy the needs that Doreen had. Doreen's reaction to the group, and the changes she had made because of it, were shared by most of the other members.

It was difficult to estimate what Audrey experienced during this stage. Audrey was 70 years old and was agile and active. She travelled a considerable distance to be with the group and at her own expense. She was a loyal member who identified with the group but who said that she enjoyed coming but was now at an age when she was content not to accept new challenges. Her daughter and grandson lived in the area and Audrey visited them and was involved in their lives. There was little evidence to suggest that Audrey changed during the period of the project.

The cohesiveness that Group 2 had achieved was noticeable during a session when their counsellor could^{not} be present. The last occasion when their counsellor could not be present the researcher had sat in but it created an artificial atmosphere. The two options on this occasion

appeared to be either, that the group met without the counsellor, or it did not ~~met~~ at all. The first alternative was selected. Considering the placid nature of this group and the dependence they had upon their counsellor when they first met it gave an indication of the development that had been undertaken and the progress that the members had made.

The session began without hesitation. The group talked congenially and Josie adopted the dominant role. The session progressed smoothly and the group maintained its cohesiveness. There were only a few occasions when diads talked together. They followed with ease the routine that had been established within the group by the counsellor. By the end of the session it was evident that Dorothy had quietly and unobtrusively taken over the leadership role. At one point Dorothy did start to talk at a feeling level. Sarah interrupted and changed the focus of conversation. The research team speculated about whether Sarah had deliberately done this because she had not consider it safe to discuss feelings without the counsellor being there.

Chapter 2 gave many examples of the psychological involvement associated with the disease process. One of the characteristics of the disease was its capricious fluctuations between periods of exacerbation and remission. One of the initial problems that the counsellors had was in creating a climate in which patients could feel comfortable in disclosing negative feelings whilst in a period of disease exacerbation. Group 1 had now reached a stage in their development when they felt comfortable in expressing negative feelings. These feelings illustrated the

disabilitating nature of the disease and re-enforced the handicap that rheumatoid arthritis can be.

Joan disclosed that she was going through a difficult period. She was lethargic and could not motivate herself. She was tired of her diet and wished to break out of the routine of eating fish. She did not look well and other members of the group commented upon it. Because of her allergy to drugs she could not take the normal non-steroidal anti-inflammatory drugs. Movement was always difficult and she walked slowly. To try and improve her movement she had ordered a pair of surgical shoes. When they had arrived she discovered that they did not fit her very well. The consensus feeling from the groups was that surgical shoes were not a success and that patients were better off with a pair of Dr. Martins.

The hopes that Pat had regarding improvement had been dashed. The initial improvement she had experienced with gold injections had stopped because she had started to have mouth ulcers. Mouth ulcers were an adverse reaction and the injections had been stopped until they had cleared up. It was a difficult blow for Pat to accept and the rest of the group sympathised with her.

Margaret had been to see her consultant who had told her that she was not improving. Margaret had been off work on the sick. She now had to face up to the fact that she would never get back. She had enjoyed her job as a nurse and had identified with the role. She recognised that her life would never be the same again and that she would have to compromise over a lot of issues. She had commented to her consultant that she had felt the need for a high fluid

intake. He told her that if she had a dry mouth then it meant that she was probably allergic to drugs. Margaret wondered if the consultant was preparing her for the fact that she would not be able to take drugs, or whether he was justifying his preferred method of drug free treatment.

The fact that Margaret could explore her feelings in the security of the group gave an indication of the progress that the group had made. The group were able to discuss feelings but not for long periods of time. Perhaps patients with a chronic illness have to confront their feelings so much that they find it emotionally exhausting to have to explore their feelings.

Group 2 discussed the issue of crying. They all accepted that it was a therapeutic process but they had differing views about when it was in order to cry. Some of the group thought it was a selfish thing to cry in front of others because it was a form of self pity. They could not cope with the idea that they were embarrassing others. Conversely they felt embarrassed when people started to cry in front of them because they thought the person had started crying because of something that they had said. The situation seem paradoxical. The counsellor suggested that crying was a sign that help was needed and that they should not cry when they were on their own. Many of the group seemed reluctant to accept this suggestion.

Dorothy had had such a hard life she had felt that her emotions had been eroded and that she was no longer able to cry. She disclosed that her husband had been her second husband and that she had to bring up step children who had

now left. She did have her daughter close to her but her daughter's husband had died suddenly last summer. Dorothy had allowed all emotional feeling to be eroded. She was a deep thinking person who could sympathise with others but who was no longer touched by her own emotions.

Ida spoke about the death of her mother. She commented that in some ways it had been a relief and she had felt that she was able to do things again. It seemed a heartless comment from someone who had been so gentle and considerate. The research team judged Ida's self-disclosure as being a sign of the confidence Ida placed in the group. She had admitted to negative thoughts and felt sure that the group would not criticise her for it.

Ida had a home help who used to come before her mother died. After her death she felt annoyed that the home help had not said anything about the death. The failure to acknowledge the death was upsetting. Ida also related an incident where she considered she had been badly treated by a doctor. The medical profession were the only legitimate source of qualified medical knowledge in society. The group thought the medical profession should be much more considerate. They should appreciate that they were the only source of legitimate diagnosis and treatment and recognise that they have a major role to play, prescribing medicine was not enough.

SUMMARY

The issue of counsellors and members' self-disclosure was important and progress in both groups had depended upon it. It was known that the amount and degree of

self-disclosure determined the pace at which therapeutic movement occurred (Bloch and Crouch, 1985). Inappropriate self-disclosure at premature psychological depth disrupted therapeutic movement and inhibited growth. This did not happen and was a sign of the cohesiveness and unity of the groups. The counsellors self-disclosed when they judged that the group's progress depended upon it. It was important to the climate of confidentiality and trust that the group counsellors self-disclosed but this did involve risk. The counselling judgements were made on the basis of appropriate timing and level of intimacy.

The self-disclosure of the group members differed widely. Maureen related to the group that on one occasion she had gone home and sat and thought about what she had said during the session. She realised that she had self-disclosed an incident that she had never revealed to anyone else. She had had a hard life as a child and had to care for her grandmother. If anybody was nice to her she immediately thought she was going to die. She had reasoned that because her life was so hard if anybody was kind it could only be because something dreadful was going to happen such as her dying.

Sarah had also talked about childhood experiences which she had kept hidden. She said that she could not tell the group but she had started to talk about it to her daughter. The members of the group had felt secure to self-disclose to whatever psychological depth they chose.

Most patients received family support to participate in the group counselling sessions, but as the

next section will show this did not always happen. The range of problems disclosed gave adequate evidence of the stigma that attached to disease (Goffman, 1963). Patients felt they were holding their normal friends back and declined invitations to go out. As a consequence they became socially isolated. Loneliness led to boredom. In turn patients felt they were boring and lost self-esteem. The disease brought feelings of shame and guilt, particularly for female patients who were trying to cope with the possibility that they had passed the disease on to their own children. There were also feelings of anger and frustration surrounding the fact that they were caught up in a medical dilemma. There was no cure for the disease and the medical profession were not sure how it should be treated. There was a range of conflicting approaches which caused insecurity and apprehension which increased their anger and frustration.

In both groups some patients disclosed more than others. There were also differences in the length and number of times patients contributed to the discussion within the groups. It has been argued, however, that the number of such contributions did not necessarily correlate with therapeutic movement (Fielding, 1983). The counsellors were aware when patients felt vulnerable and intervened to change the group's focus of attention when they considered it necessary.

Non-verbal behaviour was difficult to interpret. The disease made movement painful and patients did not always have the full range of joint flexibility. The positions that they found comfortable were not necessarily normal sitting positions. The physical deformity which the

disease caused was a source of embarrassment. Patients felt a sense of relief in the groups because they did not need to conceal their deformities. The sense of relief contributed to the climate of cohesiveness and common identity. Society has an ambivalent attitude towards physically handicapped people and it preferred them to remain out of public view (Blaxter, 1976).

This third stage gave patients the opportunity for interpersonal learning which was known to be therapeutic (Bloch and Crouch, 1985). They began to understand the effect their behaviour had upon others. In turn, they learnt how others affected them and that the group-as-a-whole as dynamically different from the first stage (Agazarian, 1983). Within the groups, the patients were respected and valued. They began to appreciate that their relationships outside the group had affected their self-concept, reducing their self-esteem. Patients began to understand that this process had taken place and that they had acquiesced in it.

They had now learnt new ways of coping with relationships and accepted each other as a role model. A reservoir of behaviour and coping skills had been established and a variety of responses had been tried out. The opportunity to experiment with different coping skills was known to be effective (Waldo, 1985). The counsellor of Group 2 used this technique to model a variety of responses that the members of the group could experiment with. The groups now moved into the final stage.

ENHANCED SELF-ESTEEM AND SELF-CONCEPT

The final stage of the group counselling now became noticeable. The move from the third stage to the final stage was slow and tentative and occurred between six to eight weeks before the end of the study. The two groups did not move into the final stage at the same time. Some members appeared much more confident and were eager to resume a more active and participatory role in the community, others needed more time and encouragement.

The activities of the research team changed at this time. Originally their meetings had been to review the video tapes and to plan activities. These meetings had been scheduled to last for two hours but the actual time had gradually lengthened and they were approximately 4 -5 hours long. Little time was now devoted to the viewing of the video tapes. The research team felt they had an understanding of what was happening and the counsellors did not need the independent opinion of the researcher to corroborate their perceptions and conclusions. The general themes underlying and linking the stages of the research were now more definite. These themes were analysed in order that a set of qualitative conclusions could be reached.

The two groups had developed and progressed. Whilst sharing a common developmental pattern they were characterised by different features. Group 1 was a strong group and some of its cohesiveness came from the anger at having a chronic disease. The anger was partly the result of the way in which they were treated as second class citizens with a spoiled identity and also from the way in which they had acquiesced and collaborated in that process. Group 2 had

discussed at length how they could now cope with the disease. They accepted that they had it and were more concerned with treatment and diet. It was recognised that the psychological effect of being on a diet tended to be negative. The person was constantly reminded that they had a limited area of freedom. The constant restriction on what they ate induced a state of rebelliousness and everybody who was on a diet came off it at some point. The psychological stress of being on a diet was not readily appreciated.

During the previous self-disclosure stage Alma had been increasingly aware that she did not feel in control of her own life. She felt that the medical profession and social agencies like DHSS were adversely affecting what happened to her. The DHSS were not co-operating. They had not granted her mobility allowance nor had they accepted any responsibility for the care of her daughter. A social worker had called at the house but Alma had been content to allow her to think that she was not in need of special care and this had annoyed the group. Her GP did not seem to accept that her circumstances were difficult, consequently her relationship with her GP was not one of confidence or trust.

She recognised that she had abrogated responsibility for her life and that a sense of helplessness had overwhelmed her. The helplessness had eroded the belief that she could influence or direct her life (Garber and Seligman, 1980). She felt she had accepted a difficult marital relationship for the sake of her daughter's security. She had given up work some time ago and was entirely dependent upon others.

Alma was a caring and sympathetic person who had identified quickly with the group. She had been open and self-disclosed much about her life. The rest of the group had responded to her in a genuine and understanding way. The group thought that Alma did not stand up for herself sufficiently and they gave her advice as to how she might do that. Joan and Helen in particular had advised Alma about whom she should see and what help she could expect. Alma displayed signs of reluctance and the group became quite impatient with her.

Alma did get in touch with the Social Services Department and another social worker came to visit. Alma presented her case with greater advocacy and with more insistence. The social worker advised her that she would be entitled to financial assistance. This assistance would take the form of providing aids for Alma to use in the house. It would also purchase an electric wheelchair which would give Alma a limited amount of mobility. She would be registered as disabled and would be given a disabled sticker for her husband's car.

Alma was an evident symbol of success for the group. In some respects her case had been simple. She had been very open and trusting in the group. She formed empathic relationships with the rest of the group and had borne her difficulties with fortitude. She had been caring of Alex. She had sent him a Valentine Card and given him an Easter Egg. She believed that deafness was the worst affliction a person could have and she had a lot of affection for him. This concern had helped her win the respect of the group.

Alma's case had been simple because she had borne her present difficulties long enough and was approaching the maturational point where she was ready to accept the challenge of change. In addition her case was a deserving one. Her physical condition was deteriorating and she could no longer cope with her disability. The counselling had enabled Alma to appreciate that she had accepted her spoiled identity without resistance. She was now more assertive and she persevered with her struggles. She was happier and had developed a strength that could be attributed to an enhanced self-concept and increased self-esteem.

After the final stage had been identified by the research team Joan self-disclosed much about her life. She had a strong personality and was respected and admired by the group. She was allergic to drugs and despite the pain she suffered she continued to keep her job. The group were aware that she was married and that her husband did not work. She had been missing for two sessions and before that she had looked tired and drained.

Joan self-disclosed a lot of her family's background. Her husband had been unemployed for some time. He looked after the house whilst she worked. He was very competent and Joan acknowledged that he did a better job in the house than she had done. The marital relationship was one in which he appeared to make her dependent upon him. Joan could not walk very easily and he pushed her in a wheelchair. He only seemed to be prepared to be involved in activities that emphasised her dependence upon him. He drove her down to the coast and then pushed her for long walks.

Joan was aware that he might be using her disease as an means of controlling their relationship.

They had four children and her husband had ended up not speaking to any of them. The last child was a girl and she had got on very well with Joan. The daughter had a boyfriend whom she was sleeping with. Joan's husband had become irrate when he had discovered the fact and said it was disgraceful and that she would have to leave. The daughter promptly left and went to live with her boyfriend whom she planned to marry.

Joan had been very close to her daughter who was now planning to get married. Her husband would have nothing to do with his daughter and whilst he did not forbid Joan to see her she knew from experience that if she did he would react in unpredictable ways. Joan wanted to be involved in her daughter's wedding plans. Joan felt increasingly trapped in this domestic situation by her husband's behaviour. Her husband suffered from bouts of depression. He was unemployed and his redundancy had affected him deeply. When employed he had worked long hours of overtime to provide for his family and this role had been important for him.

He now threatened to commit suicide on occasions. The previous week he had been depressed and had walked out late at night saying that he was going to end it all. Joan had not known what to do. She felt she could not contact her children and she did not want to inform the police. She had sat at home frightened. At two o'clock in the morning her husband returned. He told her that he had intended to go and throw himself off the railway bridge. He had walked across it but could not bring himself to jump off. Alex related

that he could sympathise with her husband over his depression. He too had suffered from depression on occasions and had found it very difficult to cope with.

In this domestic situation Joan felt trapped and constrained. She did not wish to tell her children what was happening in case the family schism became worse. She could not tell her daughter. Her husband had wanted her to stop attending the group counselling sessions. He could not understand why she wanted to attend or what possible benefit it could be to her. He saw the group as a threat and tried to persuade her not to go.

Joan stated that her husband was very good to her. He treated her kindly and with consideration. She accepted that there was little she could do without causing a major family upheaval. She acknowledged that her husband was very jealous and that he was selfishly keeping her. She could understand how she was being manipulated by him and that he used his depression and her rheumatoid arthritis to increase his control. She felt that the conflicting interests made the situation intolerable. She realised she had to make a decision and she had decided that she was going to stay with her husband. She accepted that she would not be able to see her children or attend her daughter's wedding and she had come to terms with the situation.

The group's reaction to Joan's self-disclosure was mixed. They were annoyed that her husband should use her in such a callous way, also that she had acquiesced in the situation but Joan had felt that she had no alternative. She knew her husband and believed that he would not change.

Margaret believed that her husband was trying to make Joan disabled in order that she would be completely dependent upon him. Joan was aware of this possibility and had not applied for an Invalidity Allowance nor had she contacted the Social Services Department. She felt that if she gave up work and became disabled she would be completely at the mercy of her husband.

During this session she asked if she could smoke. Her husband, she said, did not know that she smoked. The rest of the group found this difficult to believe. They referred to the 'game' that she and her husband were playing where both realised what the other was doing but it was never admitted to. Joan had found the session very useful. She said that she had 'got a lot off her chest'. It was an example of catharsis which was known to be therapeutic (Bloch and Crouch, 1985).

The rest of the group had been sympathetic and they offered support to Joan. Several said that if she got to the point of wanting to talk more about it she could ring them up at any time and they would be happy to listen. Joan's case was an example where family involvement became critical in the management of an illness. Some of the factors were discussed in Chapter 2, however, the theoretical factors did not always correlate with the reality of actual examples and there was much in Joan's case that illustrated how the complications of family relationships could be utilised in conflicts by the protagonists.

In Group 2 some of the members had lived through difficult experiences. Jenny's husband had died suddenly and

without warning from a heart attack. Jenny had found it very difficult to cope. Fortunately she had her daughter living close by together with her son-in-law. She had a good relationship with her GP who supported her admirably. She also received support from her religion. She was a devout Catholic.

Jenny could not sleep at night and moved around from bed to bed in her house. When she lay in her own bed she had the radio and the light on. One of Jenny's problems had been that her joints could 'lock' during the night. Her husband had been shown how to ease the joints. Jenny was frightened that her joints would 'lock' during the night and she would not be able to move in the morning.

When Jenny had returned to the group two sessions after her husband's death she thanked the group for their support. Jenny commented that she had been able to feel their closeness and appreciated the encouragement they had given her. She acknowledged that it had helped her. Jenny soon announced that she was taking driving lessons. Her husband's car had been sold but Jenny wanted to be as independent as possible. This was no doubt a common reaction upon bereavement. Some women had been taken everywhere and then discovered that they were dependant upon friends or public transport. No doubt some of these reasons contributed to Jenny's decision, but in her case she also had a chronic illness. The car she wanted to drive had to be specially adapted. A car had been purchased and the necessary modifications made. Jenny was very nervous about her first lesson and the counsellor talked to her about those fears

whilst the rest of the group reassured her and gave her encouragement. During the time of the counselling Jenny only had lessons and did not sit her test - which she ultimately passed. She found these very unnerving and it required courage and determination to carry on with them.

Jenny was respected and admired by the rest of the group. She was a dominant member of it and her prominence resulted from sapiential authority. Jenny's self-concept and self-esteem were still undergoing radical alteration at the end of the research. As she faced the challenge of coping with her bereavement the group had provided an effective source of therapy and support. It was impossible to decide what may have happened to Jenny if she had not had the support of the group.

Dorothy was in a similar situation to Jenny. The death of her husband had not been so much a shock as he was much older than Jenny's. Dorothy had had little warning but regretted not making the most of her husband's last days. She blamed this upon the hospital who had not advised her of the critical nature of her husband's condition.

Dorothy was 70 and claimed that her outlook had been changed by age. She no longer looked to the future with confidence, but she realised that she was spending more time going over memories of the past. In some respects she regarded that her life was over. When asked to identify a quality she had, she selected 'fairness' and 'justice'. When asked to identify a quality she would like she said - "The ability to talk to people about incidental matters instead of concentrating upon large and important issues". She had found the group a comfort after her husband's death.

She appreciated being able to get out and being surrounded by living things. At home she appreciated having a dog because it was something she could say "Goodnight" to.

The final stage had not influenced Dorothy very much. She had changed little during the course of the research. She had taken the project very seriously and seemed slightly more confident of expressing her own ideas and opinions. She had been a loyal member of the group and was to continue with it afterwards. Dorothy had suppressed her emotions and it was difficult for her to feel very much. That may account for the relatively calm acceptance of her husband's death. She seemed to have accepted in a philosophical manner that life involved suffering and pain. Her life had been a hard and painful one and she no longer wished to experience more pain, therefore she had suppressed her emotions.

There were apparent similarities with Alex. It seemed that he had accepted that his life was over and that the disease process was to increasingly handicap him. Alex did not, however, deny his emotions. It seemed that at the beginning of the project Alex was very self conscious, withdrawn and introverted. He had actually made significant progress by the end. His emotions were not so much repressed as dormant. He had experienced great delight that certain events had taken place during the research. He had been particularly pleased with his Valentine Card and had acknowledged his delight in a very formal language. Alex always behaved in a very circumspect way. He had appreciated his Easter Egg and it seemed that he had received few gifts

or had experienced the warmth of many relationships. The other members of the group were to give Alex the opportunity of experiencing that human warmth and he responded to it. At the last session he was given a plaque which had his name at the top and the rest of the group underneath. Margaret had had the plaque specially made. It was both a happy and sad moment for him and it brought tears to his eyes.

The counselling had made a difference to Alex. As a result of the information stage he realised that he could do something that might alter the course of his disease. He had started a diet which was rigorous. He had to abandon many of his favourite foods. He had persevered with his diet although it did not appear to be making very much difference to his physical condition.

He did seem to need his hearing aid less towards the end of the research. There was no suggestion that the group counselling made any difference to his hearing. It may have brought him to an acceptance of it. He said that he could only hear between 50% to 75% of what was said. It made little difference whether or not he wore his hearing aid. He appeared to be very self-conscious at the beginning about his disability but the change in his self-concept and self-esteem meant that he did not worry so much about it at the end.

Alex's enhanced self-concept and self-esteem improved his ability to mix and he felt more comfortable in the presence of women. He had recounted that he would not have been able to cope at the beginning if he had been the only man in the group. After five weeks he watched with some trepidation the departure of John. John had been in the same

age range as himself and had shared similar experiences, such as becoming redundant. Dave, who was the only male left, was considerably younger, married, employed and had children. He could not relate so well to Dave. When Dave left he was isolated. The regard with which the other members held him and the reward he got out of membership obviously made continued attendance worthwhile. In many ways it was a mark of the success of the group that it had created a supporting climate and warm atmosphere that kept Alex within it. Alex had benefited from being in mixed company. For many sessions of the initial sessions he had sat and said very little and no apparent benefit had accrued, however, it seemed evident that the contact had pleased him.

The group counselling in medical settings was an area where little research has been done and it would have been interesting to make an evaluation between group counselling as opposed to individual counselling. Group counselling gave Alex the opportunity to sit in the same room as women without feeling any responsibility to talk to them. If the problem of Alex's shyness had been approached through individual counselling then Alex would at some point have had to face up to the challenge of entering female company and conversing. There was no evidence to suggest that Alex had made new female contacts outside the group. Alex was one of the members who freely admitted to the benefits he had received because of the research project.

In Group 2 the person who most freely admitted to the benefits of the research was Sarah. She had started the

project at the point when she had been withdrawing from social contacts. The group sessions made her realise that she had acquiesced in this process. She had stopped going out and she was becoming a recluse. The disease had made her suffer humiliating experiences and she had accepted the stigma of a spoiled identity.

Sarah had self-disclosed in stage three that she had left her husband, although she had never given the reason. Her husband then contracted a terminal illness and she had returned to him and nursed him until he died approximately twelve months later. Sarah had two children, a son and a daughter. Her son lived very close to her but her daughter lived a considerable distance away. Her son had refused to have anything to do with her since she had left his father. She was emotionally close to her daughter. She would telephone each week and would visit regularly.

After the project had been running for approximately six weeks Sarah had related to the group that her daughter had told her that she had noticed that there was a change in her. She seemed more confident and more interested in community activities. Sarah had started to go dancing again. At first she sat and watched but then she had danced. The amount of dancing had increased. She clearly enjoyed it and although she suffered pain and stiffness, particularly the next morning, the benefits outweighed the disadvantages.

As was noted above Sarah became a focal point for the group. She was able to recount the events of the week to the group. She had received a Valentine Card but did not know who sent it. It had the desired affect, both on Sarah

and the rest of the group. The suggestion of romance appeared to be a major therapeutic factor in the lives of women.

Sarah did start to go out with a man much to the delight of the group. She visited a theatre which she had never been to before. She started a diet that she enjoyed, although she abandoned it at times, particularly when she was with her grandchildren.

The group helped Sarah reassert herself and she felt an obligation not to let them down. She was now engaged in a lot of activities and this was reflected in the enhancement of her self-concept and self-esteem. One of the more traumatic experiences that Sarah had suffered was the visit to her GP which had been prompted by her consultant when she had requested a bus pass to allow her to go swimming. Her GP had refused the request stating that bus passes were for people who were really disabled.

Sarah's self-concept and self-esteem had improved so much she was now able to return to her GP. She made an appointment and went to see her. She asked why she had not been given a bus pass. Her GP appeared quite oblivious to the incident when faced with the question and told Sarah that if she wanted a bus pass she could have one. The rest of the group were delighted to hear Sarah relate this incident. So many of them felt at the mercy of their doctor that this one example of someone standing up to their GP was a refreshing incident and one that appeared to vindicate how they felt.

The group had actively encouraged Sarah and their

support was an important factor in Sarah's development. She had felt a sense of loyalty to the group and had not wanted to let them down. The group pressure was a therapeutic factor in this incidence but the group counsellor was vigilant in ensuring the group members did not become the victims of the group-as-a-whole's ego. Sarah was able to achieve much and like Alex it was doubtful if she would have received the same encouragement from individual counselling. The cohesiveness of a group of people suffering from the same complaint appeared to be a powerful factor for promoting change.

Maureen had been in a similar situation to Sarah. Her rheumatoid arthritis had been diagnosed three years previously and the period had witnessed a gradual relinquishing of responsibilities and activities. She had to give up her job as a home help. Her husband had been made redundant so he was in the house all day as well as Maureen.

Maureen had had an austere life as a child and her son was aware of the fact. He still lived at home and tried to make Maureen's life as happy as he could. He used to suggest to her that she went out with him when he took his girlfriend out for the day. Maureen had refused to go on these car journeys because she believed that she would hold them back when they stopped and went for a walk. During the final stage of the research Maureen related to the group that she had started to go out with her son and his girlfriend. When they got somewhere and left the car she would walk at her own pace and was not so conscious about holding her son and girlfriend back.

Maureen also started to go out more into the

community. Her husband had been on the islands in the South Pacific when they had been testing the first nuclear bombs. It was suspected that his illness had been associated with this event. The law stated that armed service personnel could not sue the Queen. The legal position was that the Queen was head of the armed services and she was their employer. Maureen's husband had no one to sue to claim compensation for his medical complaint. Maureen said that she would accept the position of secretary of a local branch of ex-servicemen who had suffered from the nuclear bomb testing. Maureen had become much more self confident she began to recognise that she had potential and could be actively engaged in activities.

Edna had also become much more active. She was a widow and was house bound. She had a son and daughter. Her daughter was married to an Iraqi student who had to go back to Iraq. She saw little of her son. She gave little information about him and only mentioned that he called occasionally but she could not predict when he would come. She had been unhappily married and talked little about her husband. She had found moving house helpful after he died. She was virtually housebound because of the condition of her knees and she had not been out for six months before the group counselling started. Edna appreciated the social opportunities that the group offered her.

Edna's disease had been progressing for several years and her knees were getting much worse. She had been told that she could have a knee replacement operation but had been given no date. She was waiting patiently whilst her

physical condition continued to deteriorate. She felt less confident about being outside and the lack of confidence affected her self-concept and self-esteem. As the group counselling had progressed she became more assertive and took a more active part in the group. The group prevailed upon her to take more responsibility for herself and not to allow her life to be dictated to her.

The group's support enhanced Edna's self-concept and self-esteem. Edna rang up the hospital and asked about the date for her operation. She had complained that her medical condition was getting worse and that she needed urgent attention. She had taken the initiative and began to feel more in control of her own life once again. She had learnt that she had abrogated responsibility for her own life and the learning was an important experience for her.

Doreen had been helped in a similar way by the group. She had felt a burden to everyone and she had decided that she should stay at home and wait for her family to take her out. This arrangement had not worked well and she had soon felt isolated within the community. The group counselling seemed to commence at the point in time when Doreen was ready to rebel against her own self-imposed isolation. Doreen was one of the first members to start and go out into the community once again. She went out to the club where she had worked as a barmaid. She had been welcomed back by old friends and she found she could cope in that social situation.

Doreen had needed a wheelchair if she travelled any distance. ~~Her~~ knees were bad and she had considered having an operation. She had talked to her consultant who

advised her that her knees were not bad enough to warrant an operation, but if she wanted to have the operation he would support the request. Doreen interpreted his remarks as either the operation might help her, or her condition was so bad that an operation was unlikely to help.

Doreen decided against having the operation. She knew that in certain cases the operation was not a success and there was an element of risk involved. She had started to make progress in going out and she did not want that process to be interrupted or her social progress to be jeopardised. A male friend was taking her out for a car trip each week and she would have been reluctant to miss that luxury outing. Doreen seemed to be more confident and she was not so dependent upon her family. The new sense of liberty and the ability to control her own life was therapeutic for her.

The position of Ida was more difficult to assess. Ida had many problems beside rheumatoid arthritis. She had Sjogren's syndrome and she had problems with her eyes. At the beginning of the research she did not hold eye to eye contact with anyone and she did not hold her head up. For the first three or four sessions Ida rarely spoke. When she broke her silence it seemed very natural for her to be talking. The rest of the group were pleased that she had made a contribution and commented upon it.

At the end of the early sessions Ida was the first one to move away from the circle. There could have been a variety of reasons for this not least of which could have been her physical condition. As the research progressed Ida

did not leave the group so promptly and she had established better relationships with the other members of the group. Ida had disclosed about the death of her mother and her feelings towards the home help.

There was no evidence to suggest that the group counselling had made any difference to Ida's social life. She had not made new social contacts although she had started to go out with a cousin. Her cousin was important to Ida because she represented the only opportunity she had for getting out. Her sight was not good and she needed the support of others. Ida did seem more confident and she had formed good relationships with the rest of the group. She had a sense of humour and could keep the group amused and appeared to be very confident whilst doing it.

Ida was an unfortunate example of the way in which society can unsympathetically treat its chronically ill. She lacked many of the social skills to cope with relationships. She was not forceful and she believed that the reason why she was badly treated by her doctor was because she was not aggressive and would not fight back.

Any evaluation of the effects of the group counselling upon Josie was fraught with difficulties as her position was complicated. It may have been that the research had actually made her position worse. Josie claimed that the group had done her good, that she liked to get out and leading a normal life was important to her. From the beginning Josie always emphasised that it was important to be happy and to fight the disease. She claimed that she was not going to let the disease get her down. It soon became apparent that this was a facade and Josie was having to

pretend to maintain it.

As was noted in the previous section Josie's medical condition was complicated by other factors. She had had both breasts removed and had undergone surgery during the project for the removal of a lump on her arm. After the operation some of the group rang her up to inquire how she was. They reported that Josie seemed subdued on the telephone and reluctant to talk at any length.

When she returned to the group she made no reference to her operation or to the telephone calls. It seemed that she needed to forget the incident. When the group talked about unhappy feelings Josie commented that she had found the session worrying and that she had been upset by it. Josie denied the existence of her problems and tried to carry on regardless. She persevered with this strategy to the point where it was harmful. Before the group counselling had started she was aware two or more days before she was going to have a flare that it would occur. She did not make any allowance for the fact but struggled on trying to maintain an ordinary life.

Five weeks before the end of the project she was absent for some sessions. The counsellor rang her up to see if everything was alright or if she needed help. Josie seemed reluctant to talk on the telephone and the counsellor asked if the problem was related to home. Josie replied that it was and that she could not talk about it.

Josie's absence from the group continued. Before the last session the researcher rang her up. The purpose of the call was regarding the conclusions relating to the

effectiveness of the group counselling. The aim of the last session was to discuss what had happened and how effective the group counselling had been. Josie said that she would come to that session.

The rest of the group were delighted to see Josie again. She said that she had missed the group and the reason she had not been coming was that her husband did not want her to. He perceived the group counselling as a threat. Josie had been denying the illness because her husband would not let her acknowledge that she had one. He expected her to carry on and made no allowances for the fact that she was ill. The only way that Josie had been able to cope was to acquiesce.

She had many discussions with her husband who was reluctant to accept that there was anything wrong with her. Josie was aware that the disease was getting progressively worse and that she could not manage. The problem of struggling on was inevitably going to surface. Josie had tried to insist that her husband took notice but he claimed that it was because she went to the group that it had arisen. Josie felt that she had no alternative but to stay away whilst she continued to argue her case. The rest of the family were being dragged into the dispute and most gave their support to Josie.

It seemed that the very time Josie needed access to help from the group counselling she was denied it. The group and the counsellor could only express sympathy for Josie but the counsellor wondered whether Josie was strong enough to persevere in her struggle without help. The counsellor thought that the situation may be made worse.

There was not a comparable situation in Group 1 and it was evident that all the people involved in the research were singular and unique. The anger and frustration of Group 1 was shared by Agnes who could not understand why she had contracted the disease. Agnes had been very active and was employed as a school dinner-time helper. One day a heavy weight dropped on her foot. That incident started a series of pains which was to result in her being diagnosed as suffering from rheumatoid arthritis.

Agnes had to give her job up. She waited with fear in case the disease progressed because Agnes's sister had rheumatoid arthritis and it had severely disabled her. Her sister had lost so much weight she was now six stones and severely deformed. She crawled upstairs and found movement very painful. Agnes believed that there was a very strong hereditary factor and that it was inevitable that her physical condition would deteriorate.

During the course of the research Agnes seemed to lose some of the fear she had. She no longer seemed to expect that she would become disabled in the same way as her sister had become. Agnes had self-disclosed information about her son who she was very proud of. She also had a daughter who was at university. She still worried in case she had passed the disease onto them.

Agnes had begun to assume greater responsibility for her life. This could be seen in small events such as asking for a different chair. She commented that the usual one made her stiff the day after the group counselling. It had taken her a long time to ask. The present chair gave her

arms no support. Agnes did appear to sit awkwardly at times and it demonstrated how difficult it was to interpret non-verbal behaviour.

In common with Joan, Agnes did not like taking drugs. She was not allergic to them, but after listening to Joan she realised that they were the cause of her dizziness, nausea and sweating. She decided to give them all up. This was fraught with difficulties. Agnes took sleeping pills. If she did not she would not get to sleep and would have to get up during the night. Relinquishing her sleeping pills would put a strain upon her marital relationship. It was possible for patients to live in the same house as a normal person and rarely see them. They stayed awake during the night and slept during the day. It was clear that patients could become isolated within a marriage. Fortunately Agnes had an understanding husband who supported her in her decision to terminate her drug dosage. Agnes went to see her GP at this point to discuss the matter with him. She received no support whatsoever from him. In fact, he tried to persuade her to carry on taking the drugs. The subsequent decision to give up, was more difficult to make and the counselling support helped her to find the psychological strength to effect the original decision. Agnes coped with the increased pain but felt better for giving up the drugs.

There appeared to be little change in the self-concept or self-esteem of Pat. In addition to rheumatoid arthritis she had other medical problems not least of which was her ileostomy. Pat was a young woman whose future was inevitably bound up with many issues besides her illness. Career patterns, motherhood and marital stability were all

issues that concerned her.

Pat had attended most of the sessions although she had said from the beginning that she did not think that the research would help her but was happy to think she might be helping someone else. Pat was still looking for a medical cure or effective treatment. She was given gold treatment during the course of the research. Initially this seemed to make an improvement to her and emotionally she became happier. The treatment was to produce dangerous side effects and she had to be withdrawn from it. Sodium aurothiomalate was a highly toxic drug that required careful monitoring. Gold injections did not help everyone. The intervention inevitably confused any assessment of the group counselling. Whilst there was no suggestion that the course of treatment should not have been started there was a suggestion that the scientific model of research was inapplicable in long term research projects such as this particularly when the disease was characterised by periods of exacerbation and remission. It made the process of arriving at conclusions attentive and unsatisfactory.

During the later part of the research Helen's husband had a heart attack and he underwent a bypass operation. She was missing from the group for four weeks but then returned. In terms of her own illness Helen had only been diagnosed twelve months before. The disease process had not affected her life style except in some of the duties that she needed to fulfil in the job as warden for a home for the elderly. Her husband had been able to do these up until the time of his heart attack.

Helen was a respected member of the group. Her position of warden gave her a knowledge and power base that was extremely useful at times. She was able to tell the rest of the group what benefits they were entitled to and how they could go about getting them. Because she was ill Helen also had a social worker who was responsible for helping her. Perhaps because of her position the social worker was very helpful and advised Helen about everything. Helen was able to demonstrate to the others that this was the standard of care that was provided and that they were entitled to it as well.

Helen contributed much to the group and was instrumental in making it successful. She did not self-disclose much information about her own feelings and seemed introverted about personal details. Perhaps her husband's heart condition made her wary of delving too deeply into her emotions. The group removed much of her apprehension about the way in which the disease might progress. She seemed confident about the future. Helen had enjoyed the group counselling. She knew that there was no medical cure or effective treatment and the counselling appeared to equip her for the challenge that was yet to come.

The spiritual healing that Rita had experienced was still having the same effect. She had not had any more pain and her stiffness continued to ease. In the light of this experience it was difficult to make an assessment as to how the counselling helped Rita. The pain associated with rheumatoid arthritis was particularly wearisome and to be relieved of it, affected the patient's perception of their entire life.

The fact that the pain left does support the argument that there was a psychological dimension to rheumatoid arthritis. Rita's experience made evaluation more difficult. She did appear to enjoy the group experience and she did remark that she found it stimulating.

Margaret had been a nurse and she thought that she understood the position that patients found themselves in. She soon discovered that she understood little of what it meant to be a patient suffering from rheumatoid arthritis. She was prepared to accept the group counselling as a learning experience and as a consequence derived much benefit from it.

She was a very forceful character who competed for leadership of the group. She did have sapiental authority to begin with. Authority was particularly useful in task oriented groups but the group had no clearly defined task. The group members needed security and support to talk at a meaningful level about their reactions to rheumatoid arthritis. Unfortunately Margaret did not appear to recognise this need nor did she display the skills to create the optimum climate. In addition Margaret was missing for several sessions having her teeth extracted and dentures fitted. Her absence coincided with the time when the group entered the self-disclosure stage. When she came back Margaret found that the group was very different from the one she had left. The climate had been created where the members were prepared to self-disclose. Margaret had missed out on the transition from one stage to the next and appeared to feel at a loss.

From Margaret's comments it was evident that much of her sense of identity came from the fact that she had been a nurse. Only after several sessions did she confide that she was not working at present but was on the sick. Having to relinquish her job was a personal loss. It was only half way through the project that she had to accept that she would never return to work.

She was angry about the way in which she was treated by the consultants. To begin with she appeared to accept that there was little that could be done for her but as the disease progressed she clearly had a need for medical treatment. She changed her consultant but came to appreciate that he could not offer any effective therapy. She finally accepted that it was her responsibility to face up to the challenge of coping with her illness. As the counselling progressed through the final stage she appreciated the emotional and mental journey she had been on and that she felt better. Her self-concept and self-esteem had improved.

SUMMARY AND CONCLUSIONS

Members of both groups' attitudes towards pain changed during the course of the research. They came to accept pain as a concomitant of life as well as rheumatoid arthritis, rather than something that needed to be avoided. It became evident that society had an ambivalent attitude towards pain. Pain was not always perceived as a destructive experience. Society acknowledged that pain does have positive benefits as a consequence of certain experiences. Sportsmen are encouraged to train through 'pain barriers'. The more pain they could endure then the physically fitter

they were. Pain was an essential part of life and contributed towards pleasure. The feeling of pain upon orgasm was an experience that most people appeared to enjoy. There were also those who enjoyed pain in much more bizarre circumstances. What seems to be critical was the ability to control the pain. Pain was not seen as a debilitating experience if the individual had it within his power to stop it. It may^{be} the inability to control pain which caused the sense of incapacity rather than the degree to which it was experienced.

The group counselling had provided the opportunity for the patients to review some of the events of their lives. This process had allowed them to gain a new insight and understanding of those events. Resolving the personality conflicts allowed the patients to come to a greater acceptance of themselves as complete people and to feel more comfortable with the differing parts of their personality. As the patient's self-concept and self-esteem had improved they were able to set more realistic targets and standards for themselves. This process lessened the tension and stress that they had felt.

The groups had benefited from the therapeutic factors of cohesiveness, catharsis, insight and interpersonal learning (Butler and Fuhrman, 1983). These factors encouraged patients to take responsibility for their own lives. They no longer depended solely upon the medical profession for their health care but assumed the initiative in trying new non-drug treatments. They did not feel as helpless nor did they accept a spoiled identity (Goffman,

The previous stage of self-discovery had given patients a new perspective on their lives. They appreciated they had succumbed to the effects of a debilitating disease. They understood that before joining the project they had given up social contacts and had become isolated within the community. The process was now reversed. The patients had gone back into the community and re-established links with friends. They were encouraged by able-bodied friends to participate in social activities and their feelings of isolation and boredom were reduced. They no longer considered themselves to be boring.

The group counselling had reduced the patients' sense of helplessness and increased their determination to lead as active a life as possible, accepting that pain need not always be debilitating. The groups were very supportive of their members during this stage and encouraged them to become more independent. The patients took an obvious delight in being able to report new experiences to the group and each individual success was regarded as a group success. Their new interpersonal skills had improved their self-concept and self-esteem.

The members of both groups felt increased cohesiveness within the group. They felt reduced depression and decreased friction in personal relationships, as well as an increased ability to cope with the challenge of their physical condition. They experienced a promoted sense of friendliness, independence and sociability.

The process of monitoring the progress of the two groups had been a successful one. Much useful information

had been discovered and a more comprehensive understanding of how rheumatoid arthritis affects individuals had been made. This evaluation had been possible because a new paradigm research methodology had been incorporated into the research design. The group counselling had been a therapeutic experience for the patients and the final evaluation will be carried out in Chapter 6.

Chapter 6

RESULTS , , CONCLUSIONS

AND RECOMMENDATIONS

INTRODUCTION

This chapter reports the results of the qualitative and quantitative evaluations and gives the conclusions of the study. The chapter is divided into 3 sections. Section 1 gives the qualitative and quantitative results and describes the processes involved in arriving at those results. The two sets of results do not corroborate with each other. The qualitative results show that group counselling has been a therapeutic intervention for this group of patients and has illuminated the psychological concomitants of the disease. The quantitative results show that the group counselling has made no difference to this set of patients on the selected measures. The selected measures are neither negative nor positive, and do not show a statistical difference ($p=.05$).

Section 2 discusses why the qualitative and quantitative results are different. It investigates possible reasons including sources of error, neglect and bias. It describes the qualitative and quantitative results alternatively, analysing their relative strengths and weaknesses. The section suggests that whilst the two sets of results do not agree they do not directly contradict each other. In this situation it is argued that the positive qualitative results should be adopted in favour of the neutral quantitative results.

Section 3 states the conclusions of the research. The conclusions consider the qualitative and quantitative results in the wider context of the research. The qualitative results concentrated upon the processes of the group counselling whilst the quantitative results concentrated upon assessing outcomes. Neither is a definitive statement on their own but they both need to be considered together. For example, the results of the clinical and psychological measurements were not available when the qualitative results were drawn up and these need to be included. The contribution of each to the conclusions is assessed.

Section 1

QUALITATIVE RESULTS

The qualitative results are based upon the evidence of the fieldwork discussed in Chapter 5. The fieldwork was conducted on the theoretical basis of humanistic psychology as presented in Chapter 3. It was argued in Chapter 4 that the research methodology appropriate to humanistic psychology was ^{the} new paradigm. Some of the research techniques of new paradigm research methodology were video recording, conversation and observation (cf. Ginsburg, 1979). Video recordings of the group counselling sessions were made to allow the process to be recorded and investigated. The video recordings together with the counsellors' observations and the research team's conversations provided the data base which allowed the qualitative results to be reached.

The fieldwork discussions that took place at the weekly meetings of the research team allowed the four stages to be identified. These stages were discussed in the previous chapter. An analysis of the data allowed the research team to arrived at certain tentative results. These results were deduced from the data base of the video recordings, the researcher's and counsellors' perceptions, conversations and observations. The process of triangulation adopted by the research team allowed a consensual set of results to be negotiated (Adelman, 1977). The qualitative results were represented by a set of written statements.

The statements represented the opinions, views and conclusions of the research team. The process of triangulation, rigorously applied, still had to accept that the statements could have contained the unconscious bias of the research team. These statements, in turn, sought to represent the opinions, views and beliefs of the patients. Their validity and reliability could be authenticated by asking the patients to corroborate that they represented their views, opinions and beliefs accurately. This process of respondent validation guaranteed that the patients were consulted and that the statements were accurate (Bloor, 1978).

In following the process of respondent validation the research team decided that the patients should be given a copy of the statements to vouchsafe their accuracy. The statements were given out at the end of the penultimate group counselling session together with the psychological questionnaires which were to provide the post-test data. A package of the psychological questionnaires and qualitative

statements was handed to the patients in a large envelope which also contained spare paper. They were asked to read the statements during the week and make any comments that they wished on the spare paper. They were informed that the final session would include time for a discussion of the statements.

The researcher had experienced some difficulty in wording the statements. There were significant differences between the specialised psychological vocabulary of the researcher and the vocabulary of the patients. It was evident that some psychological terms did not translate easily or comfortably into an ordinary vocabulary. There was a risk that the statements could be widely misinterpreted if a precise vocabulary was not used and the meaning of the statements distorted. A concept such as learned helplessness had a psychological definition that would not have been immediately obvious to the patients. If the concept had been expressed as 'they had learned to be helpless' it may have been misinterpreted by the patients. A compromise solution was adopted and the statements were expressed in two ways, firstly with psychological precision then followed by a more everyday language set in brackets. The patients were advised of this procedure and the reasons for it.

There were 27 statements which were divided into two sections, Section 1 giving the psychological concomitants of rheumatoid arthritis, and Section 2 an evaluation of the therapeutic effect of the group counselling. The Sections were -

Section 1

1) The disease of rheumatoid arthritis affects most aspects of a patient's life and coping with the disease requires a lot of psychological strength. (You need to feel well to be able to face up to things.)

2) There is a need for the psychological support of patients which at present is unmet. (Sometimes people just need a little bit of help to keep going and at the moment that help is not there.)

3) Many of the psychological problems experienced by patients are caused by the variable nature of the disease process. The fact that exacerbations and remissions cannot be predicted increase the patient's sense of insecurity which contributes towards a state of learned helplessness. (Because you don't know from one day to the next how you will feel, you cannot plan what you are going to do and this makes you feel helpless.)

4) The variable and unpredictable nature of the disease activity caused the significant relationships that patients have, to be under continual negotiation, compromise and redefinition. This process places considerable strain on those relationships and upon the patients. (Because you cannot do things on certain days you have to rely upon others and you don't like asking them all the time. Eventually some people have to accept that partners have to take over certain household chores.)

5) The advice and information given by different members of the medical profession is inconsistent and contradictory, of little practical value, and a source of stress and tension for patients. (Some doctors tell you one

thing, other doctors tell you something different. This makes patients unsure and causes worry.)

6) The opinion that patients have formed regarding the standard of medical care they receive is not pejorative. Patients realise that they have a chronic condition for which there is no cure, and whilst doctors and consultants are genuinely trying to provide medical help, there is in fact little they can do. (Patients are not being critical of doctors but understand they are trying to help, but because there is no cure they find it difficult.)

7) The social agencies that are sometimes involved, like the DHSS, have little understanding of the disease or its effects and their ambiguous and contradictory attitude increases the stress and tension patients experience. (The reason why some patients get an allowance whilst others do not is difficult to understand.)

8) Patients would prefer to learn to cope with the pain and tiredness that the disease brings whilst maintaining as normal a life as possible, rather than relying upon medical intervention. (Its better to have the pain and as normal a life as possible than going to the doctor.)

9) Patients have found that it is possible to feel psychologically strong while the disease is very active and it is more important, when coping with the disease, to feel psychologically strong rather than physically strong. (Patients feel better when they are happy and occupied and it is better to feel like that than physically strong when coping with the disease.)

10) The primary concern of patients is the quality of their lives but the primary concern of the doctors would appear to be the disease process. These two different approaches give rise to the patient's suspicion that doctors are more interested in the disease than in the patients as people. (Doctors tend to think of just the disease and not how it is affecting other aspects of a patient's life.)

11) Because of the inconsistent and contradictory advice given by medical practitioners patients do not follow their instructions but adapt them in the light of what they think best for themselves. (Patients know their own bodies' best and just take whatever medicine they feel necessary.)

12) Patients find that requiring medical treatment, encourages a state of learned helplessness when patients become dependent upon doctors. This situation is not conducive to a patient's sense of psychological well-being. (Being under the doctor is not good and it makes patients feel helpless.)

13) It is important that patients re-assume responsibility for their own life and this can often be achieved by making small alterations to their life style or thinking. (Trying once again to do things helps patients get in control and feel better.)

14) By assuming responsibility for their lives once again patients gain some new insight into their behaviour which prevents them becoming as helpless. (Patients have learned things about themselves and now feel better able to look after themselves.)

15) Rheumatoid arthritis affects many aspects of a patient's life and there is a tendency to ascribe everything

that happens to them to the disease. Patients do not appreciate that there can be other causes. (Patients tend to blame the disease when they are tired etc. and forget that things like ageing naturally make us feel more tired.)

16) The response of each patient to the disease is singular and unique in psychological terms. Each patient needs their doctor to recognise this when giving them medical advice or prescribing drugs if treatment is to be effective. (What works for one does not work for everyone and patients need individual treatment.)

17) In social terms the disease has a general underlying tendency of making all the patient's relationships more difficult to manage and that patients become increasingly socially isolated. (It is easy to sit at home and not make the effort to get out.)

18) Members of the general public find it difficult to know how to behave towards patients suffering from rheumatoid arthritis in an understanding and compassionate way. They either, ignore the fact that they have any problems, or treat them as if they were abnormal, and neither is satisfactory. (People never seem to know when patients need help or how to give it to them.)

Section 2

19) Group counselling can satisfy the need that patients have for psychological support which in turn leads to a sense of psychological well-being. (Belonging to the group has helped patients cope.)

20) The group counselling has encouraged patients to experiment with new behaviours and to re-establish old

behaviours. This has helped patients to regain control of their lives. (Going out again and leading as normal a life as possible has helped.)

21) The groups have achieved cohesiveness and a common identity. This has allowed patients suffering from the same disease to feel normal within a group of people suffering from the same complaint. (The group has felt strong and patients have felt close to each other.)

22) The group members have exchanged information about how the disease affects them and how they cope with the consequences of it. This has allowed members to allay fears about the future and to better understand new physical symptoms and whether they are associated with the disease. (Patients have realised that a symptom like buzzing in the ears can be caused by the disease and this has stopped them worrying.)

23) Through the process of information exchange and group interaction, group members have come to learn and understand that there are a number of different responses they can make to any medical situation and this has increased their confidence in their ability to cope. (Patients have learnt that different people deal with different things in different ways and now they have more ways in which to react to different situations.)

24) The members of the groups appreciated that they were becoming socially isolated and they therefore encouraged each other to make new social connections and to re-establish old ones. Patients achieved much satisfaction in being able to report back to the group any successes they

had in doing this. Rewards and encouragement were an important part of this process. (It has been good to get out again and to tell everybody in the group about it.)

25) Being a member of the group has taken away the sense that patients were inferior or disadvantaged in some way. Belonging to the group had given patients the security and confidence to stand up for themselves again and not to allow others to treat them as if they were inferior or disadvantaged in some way. (It is nice to think that we are no longer different.)

26) The group has given members the opportunity to disclose emotional problems in an atmosphere of confidentiality and trust and this has had a therapeutic effect. The self-disclosure has allowed the cohesiveness of the group to increase. (Patients have felt better when they have been able to get things off their chest.)

27) The group counselling has promoted in patients an enhanced self-concept and self-esteem. They now have increased confidence and self-respect. This process has lead to greater psychological strength which had allowed them to face up to the challenge of living with rheumatoid arthritis. (The group counselling has worked. We feel better and able to face up to life once again.)

GROUP DISCUSSION

The researcher attended the last group counselling session of the research to discuss the qualitative results with the group. The researcher introduced the discussion by saying that his concern was to report as accurately as he could what had happened during the research and what the

results were. He said that any comments or alterations they would like to make would improve the accuracy of the results.

There was general agreement that the qualitative results were accurate. The patients remarked that they had not found the simplified statements to be of any help and it seemed that some were slightly irritated that a presumption about their ability to understand had been made - the precaution had not been successful. Three suggestions were made to improve the accuracy of the statements and after general discussion the alterations were adopted.

1) There was a feeling that point 8 should include reference to the side effects of drugs. The groups felt that they would prefer to cope with the pain and tiredness of the disease than suffer the dizziness, nausea and sense of being unwell that were the side effects of the drugs.

2) The groups stressed that the counselling should be available from the time of initial diagnosis. Some felt that they had deteriorated since they had been diagnosed and this would not have happened if they had received group counselling straight away. Point 19 was altered accordingly.

3) The groups maintained they had learned from each other that a number of different responses were available in social situations as well as medical situations. This addition was made to Point 23.

These alterations were suggested during the final group counselling session. The researcher wished to discover whether the patients had made alterations to the statements that they had not mentioned during the final session. There

was no evidence to suggest that the patients had been intimidated in the group setting. In seven cases the spare paper had been signed confirming that the statements were accurate. This process of respondent validation was useful and helped to make the results more reliable, valid and objective. The final set of statements had been arrived at through a process of negotiation and compromise. They now became:

Section 1

1) The disease of rheumatoid arthritis affects most aspects of a patient's life and coping with the disease requires a lot of psychological strength.

2) There is a need for the psychological support of patients which at present is unmet.

3) Many of the psychological problems experienced by patients are caused by the variable nature of the disease process. The fact that exacerbations and remissions cannot be predicted increase the patient's sense of insecurity which contributes towards a state of learned helplessness.

4) The variable and unpredictable nature of the disease activity causes the significant relationships that patients have to be under continual negotiation, compromise and redefinition. This process places considerable strain on those relationships and upon the patients.

5) The advice and information given by different members of the medical profession is inconsistent and contradictory, of little practical value and a source of stress and tension for patients.

6) The opinion that patients have formed regarding

the standard of medical care they receive is not pejorative. Patients realise that they have a chronic condition for which there is no cure, and whilst doctors and consultants are genuinely trying to provide medical help, there is in fact little they can do.

7) The social agencies that are sometimes involved, like DHSS have little understanding of the disease or its effects and their ambiguous and contradictory attitude increases the stress and tension patients experience.

8) Patients would prefer to learn to cope with the pain and tiredness that the disease brings whilst maintaining as normal a life as possible, rather than relying upon medical intervention. This position is preferable to taking drugs and suffering from possible side effects.

9) Patients have found that it is possible to feel psychologically strong while the disease is very active. It is more important, when coping with the disease, to feel psychologically strong rather than physically strong.

10) The primary concern of patients is the quality of their lives but the primary concern of the doctors would appear to be the disease process. These two different approaches give rise to the patient s' suspicion that doctors are more interested in the disease than in the patients as people.

11) Because of the inconsistent and contradictory advice given by medical practitioners patients do not follow

their instructions but adapt them in the light of what they think best for themselves.

12) Patients find that requiring medical treatment encourages a state of learned helplessness when patients become dependent upon doctors. This situation is not conducive to a patient's sense of psychological well-being.

13) It is important that patients reassume responsibility for their own life and this can often be achieved by making small alterations to their life style or thinking.

14) By assuming responsibility for their lives once again patients gain some new insight into their behaviour which prevents them becoming as helpless.

15) Rheumatoid arthritis affects many aspects of a patient's life and there is a tendency to ascribe everything that happens to them to the disease. Patients do not appreciate that there can be other causes.

16) The response of each patient to the disease is singular and unique in psychological terms. Each patient needs their doctor to recognise this when giving them medical advice or prescribing drugs if treatment is to be effective.

17) In social terms the disease has a general underlying tendency of making all the patients' relationships more difficult to manage and that patients become increasingly socially isolated.

18) Members of the general public find it difficult to know how to behave towards patients suffering from rheumatoid arthritis in an understanding and compassionate way. They either ignore the fact that they

have a problem, or treat them as if they were abnormal, and neither is satisfactory.

Section 2

19) Group counselling can satisfy the need that patients have for psychological support which in turn leads to a sense of psychological well-being. This support should be available from the time of initial diagnosis and should not be seen as remedial provision.

20) The group counselling has encouraged patients to experiment with new behaviours and to re-establish old behaviours. This has helped patients to regain control of their lives.

21) The groups have achieved cohesiveness and a common identity. This has allowed patients suffering from the same disease to feel normal within a group of people suffering from the same complaint.

22) The group members have exchanged information about how the disease affects them and how they cope with the consequences of it. This has allowed members to allay fears about the future and to better understand new physical symptoms and whether they are associated with the disease.

23) Through the process of information exchange and group interaction, group members have come to learn and understand that there are a number of different responses they can make to any medical or social situation and this has increased their confidence in their ability to cope.

24) The members of the group appreciated that they were becoming socially isolated and they therefore encouraged each other to make new social connections and to

re-establish old ones. Patients achieved much satisfaction in being able to report back to the group any successes they had had in doing this. Rewards and encouragement were an important part of this process.

25) Being a member of the group has taken away the sense that patients were inferior or disadvantaged in some way. Belonging to the group had given them the confidence to stand up for themselves again and not to allow others to treat them in that way.

26) The group has given members the opportunity to disclose emotional problems in an atmosphere of confidentiality and trust and this has had a therapeutic effect. The self disclosure has increased the cohesiveness of the group.

27) The group counselling has promoted in patients an enhanced self-concept and self-esteem. They now have increased confidence and self-respect. This process has lead to greater psychological strength which has allowed them to face up to the challenge of living with rheumatoid arthritis.

From these statements it was evident that the group counselling had allowed the psychological concomitants to be illuminated and that the group counselling had been a therapeutic intervention. The reliability, validity and objectivity of these results will be discussed in Section 2.

Video Recordings

The written statement which was the basis of the initial contract that had been established with the patients at the commencement of the research referred to the video

recordings. The statement gave a guarantee 'That group counselling sessions will be recorded on closed circuit television but the recordings will be ~~erased~~ at the termination of the study unless patients give their consent that they can be retained.'

The researcher wished to discuss with the patients whether they would be agreeable to the recordings being kept at the end of the study and being used for teaching purposes. The researcher discussed the subject with the counsellors at the research team's meeting. One of the counsellors objected to the idea. The counsellor presented the argument that as the group counselling had progressed and the climate of trust and confidence within the group had developed she had self-disclosed without thought of confidentiality. Some of her comments referred to personal problems with colleagues and she would not want anyone to have access to the video tapes. It may well have been that the people to whom the tapes were shown would include colleagues or students who might recognise who the comments referred to. In accordance with the counsellor's wishes the groups were never asked for permission to use the video tapes for other purposes.

The researcher did ask the groups whether the presence of the video camera had affected the comments they had made. The groups were quite firm in their assertion that the camera had not affected what they had disclosed. They had been aware of the camera at the beginning but after a while it had not figured in their consciousness.

QUANTITATIVE RESULTS

During the final session the patients returned the completed questionnaires and the clinical measurements were re-taken. The reasons for the selection of the tests were discussed in chapter 4. The psychological and clinical tests tests were:

Arthritis Helplessness Index (AHI) (Nicassio et al., 1985);

Multidimensional Health Locus of Control (MHLC) (Wallston et al., 1978);

McGill Pain Questionnaire (McGill) (Melzack, 1975);

Beck Depression Inventory (Beck) (Beck, 1961);

Arthritis Impact Measurement Scale (AIMS) (Meenan et al., 1982);

Ritchie Articular Index (Ritchie) (Ritchie et al., 1968);

Pain Visual Analogue Scale (Pain VAS)

Stiffness Visual Analogue Scale (Stiffness VAS)

Haemoglobin Measurement (Hb)

White Blood Cell Count (WBC)

Platelets Measurement (PLT)

Erythrocyte Sedimentation Rate (ESR)

Rheumatoid Factor (RF)

Some of the questionnaires have sub-scales and these are shown in the Tables. The scores for each patient were calculated. These scores were then aggregated into mean scores for the groups. Table 1 gives the mean group scores for each of the measures on the pre- and post-test design. The three groups are shown separately.

TABLE 1

Gives Mean Group Scores For The Three Groups On Pre- (Jan)
and Post-Test (July) Measures

	Group 1		Group 2		Control	
Average Group Scores	Jan	July	Jan	July	Jan	July
AHI	34.4	37.6	34.3	34.8	32.1	31.7
MHLC						
Internal Items	21.4	18.0	20.3	22.2	21.3	19.7
Chance Items	18.1	20.2	19.9	21.3	18.6	18.8
Powerful Others Items	16.5	16.7	14.8	15.4	21.3	21.9
McGill						
Sensory	15.4	12.5	10.0	9.8	8.9	9.8
Affective	8.5	7.2	2.4	2.4	4.8	3.3
Evaluative	1.7	1.2	1.7	0.7	2.1	1.4
Number Words Chosen	13.7	11.0	8.6	7.9	8.0	7.4
Pain Rating Index	31.1	25.7	16.0	17.3	21.6	21.0
Present Pain Index	2.4	2.4	1.8	2.3	2.8	2.6
Beck						
Depression	11.4	12.6	11.7	12.4	16.1	16.7
AIM						
Mobility	5.7	6.4	5.3	5.4	7.8	8.4
Physical Activity	8.6	8.6	8.2	8.1	6.3	6.0
Dexterity	7.9	9.2	7.2	8.3	9.3	9.6
Household Activity	10.0	10.7	9.7	9.6	8.7	8.8
Social Activity	14.1	12.7	12.3	9.9	13.6	12.8
Daily Living	5.6	6.6	4.3	4.7	7.7	8.1
Pain	18.5	17.7	14.7	16.1	13.7	13.4
Depression	14.4	12.7	13.9	14.0	18.3	18.7
Anxiety	17.7	17.4	18.4	22.4	18.1	19.7
Health Perceptions	9.5	9.5	10.7	7.8	12.7	12.1
Arthritis Impact	31.2	41.0	42.7	41.6	48.3	48.3
Total	143	154	148	148	164	165

TABLE 1 (Cont')

	Group 1		Group 2		Control	
	Jan	July	Jan	July	Jan	July
Haemoglobin	12.1	11.8	12.0	11.9	11.9	10.9
White Blood Cell	9.0	8.8	7.6	7.8	7.8	7.6
Platelets	454	480	432	448	342	396
E S R	45.6	43.3	43.7	51.9	52.9	59.3
R F	1/32	1/32	1/60	1/60	1/32	1/32
Ritchie Articular Index	21.4	22.0	14.7	17.7	14.4	19.0
Pain VAS	53.7	47.3	38.6	35.6	34.8	43.2
Stiffness VAS	74.2	59.7	40.2	49.3	52.7	55.6

In assessing the differences between the means for the groups the Mann-Whitney U-Test was used. This was a useful non-parametric test to evaluate the difference between population distributions. With the test it was possible to obtain a significant difference between groups when the means were identical (Cohen and Holliday, 1982). The test shows whether the two independent groups have been drawn from the same population (Seigel, 1956).

The results of the Mann-Whitney U-Test are given in Table 2. The table compares the difference between the group means. The comparisons between Groups 1-2, 2-3 and Groups 1-3 (Group 3 being the Control Group) show whether the level of probability was significant. There was little evidence to suggest that this was the case. The Powerful Others Items of the HMLC Scale did show a significant difference ($p=.05$) in July although the difference was also shown to be there in the January. Of the 25 actual differences only 12 of those show a significant difference ($p=.05$) at the end of the group counselling.

TABLE 2

Mann-Whitney U Test- Gives Probability ($p=.05$) On Pre- And Post-Test Measures Comparing The Groups With Each Other.

	Groups 1-2		Groups 2-3		Groups 1-3	
	Jan	July	Jan	July	Jan	July
AHI	.469	.174	.169	.119	.383	.033
MHLC						
Internal Items	.699	.081	.929	.249	.699	.771
Chance Items	.597	.735	.504	.350	.884	.440
Powerful Others Items	.736	.529	.036	.003	.042	.018
McGill						
Sensory	.111	.358	.964	.894	.072	.382
Affective	.013	.017	.414	.891	.173	.036
Evaluative	.299	.212	.649	.206	.539	.841
Number Words Chosen	.033	.287	.564	.929	.033	.176
Pain Rating Index	.034	.247	.353	.790	.135	.412
Present Pain Index	.058	.916	.197	.926	.726	.960
Beck						
Depression	1.000	.772	.657	.894	.663	.735
AIMS						
Mobility	.541	.376	.022	.031	.068	.108
Physical Activity	.389	.720	.102	.048	.020	.004
Dexterity	.693	.090	.031	.032	.034	.311
Household Activity	.883	.236	.348	.531	.260	.160
Social Activity	.439	.285	.350	.073	1.000	.733
Daily Living	.020	.016	.002	.004	.131	.284
Pain	.042	.408	.626	.288	.190	.101
Depression	.661	.698	.183	.155	.209	.042
Anxiety	.884	.247	.689	.929	.809	.469
Health Perceptions	.498	.439	.504	.090	.133	.384
Arthritis Impact	.351	.541	.529	.823	.067	.436
Total	.809	.500	.309	.199	.247	.386

TABLE 2 (Cont')

Mann-Whitney U Test (Cont')

	Groups 1-2		Groups 2-3		Groups 1-3	
Haemoglobin	.809	.928	.756	.563	.847	.496
White Blood Cell	.289	.353	.859	.791	.335	.757
Platelets	.699	.588	.122	.757	.063	.536
E S R	.961	.643	.929	.791	.923	.853
R F	.920	.812	.142	.475	.323	.632
Ritchie Articular Index	.192	.312	.625	.690	.211	.366
Pain VAS	.135	.524	.723	.565	.289	.957
Stiffness VAS	.016	.363	.330	.626	.123	.710

p= .05

The Mann-Whitney U-Test showed that while some results were significant the majority of the differences between the groups were below the .05 level of significance when compared with each other either before or after the group counselling intervention.

There was no difference between the groups when compared against each other in Table 2. If there was no significant differences between the groups then perhaps there was a significant difference between the individual scores for each group on the pre- and post-test measures. The Wilcoxon Matched-Pairs Signed-Ranks Test allows each group to be assessed on the pre-and post-test measures. (Guilford, 1973). The test overcomes the difficulty imposed by extraneous differences between groups and uses two related samples that were matched. The matching was achieved by using each subject as his own control (Seigel, 1956). Each subject includes two measures, one taken in the January and the second in July.

TABLE 3

Wilcoxon Matched-Pairs Signed-Ranks Test - Gives Probability
($p=.05$) Comparing The Pre- and Post-Test Results For Each
Group

	Group 1	Group 2	Control
AHI	.183	.362	.812
MHLC			
Internal Items	.108	.674	.109
Chance Items	.575	.528	.600
Powerful Others Items	.735	.674	.514
McGill			
Sensory	.161	.833	.192
Affective	.575	1.000	.115
Evaluative	.327	.027*	.138
Number Words Chosen	.262	.441	.624
Pain Rating Index	.352	.479	.262
Present Pain Index	1.000	.177	.422
Beck			
Depression	.753	.859	.594
AIMS			
Mobility	.418	.787	.138
Physical Activity	1.000	.833	.224
Dexterity	.042*	.293	.463
Household Activity	.179	.685	.753
Social Activity	.327	.207	.123
Daily Living	.108	.179	.236
Pain	.779	.400	.575
Depression	.352	.722	.905
Anxiety	.624	.173	.091
Health Perceptions	1.000	.038*	.398
Arthritis Impact	.248	.833	.779
Total	.575	.952	.812

TABLE 3 (Cont')

Wilcoxon Matched-Pairs Signed-Ranks Test (Cont')

Haemoglobin	.855	.635	.362
White Blood Cell	.144	.678	.952
Platelets	.285	.441	.011*
E S R	1.000	.477	.441
R F	.317	.293	.138
Ritchie Articular Index	.753	.327	.020*
Pain VAS	1.000	.767	.286
Stiffness VAS	.310	.213	.812

p=.05

The Wilcoxon Matched-Pairs Signed-Ranks Test gave no evidence that the results were significant. If the measurements had detected a difference then the difference between the January and July results for Group 1 and Group 2 would have been statistically different. From Table 3 it was noticed that there are only five results which were above the .05 significance level. Of the five, one occurred in Group 1, two in Group 2 and two in the Control Group. There was no suggestion from these results that the group counselling had made a significant difference to the groups.

The lack of definite results may have been attributable to the size of the groups. Groups of this size were unlikely to give positive results using small sample numbers but by combining the three groups it was possible to discover if the increased number of cases would be above the level of significance. Table 4 gives the results of this aggregate using the Wilcoxon Matched-pairs Signed-ranks Test.

TABLE 4

Wilcoxon Matched-pairs Signed-ranks Test - Gives Probability
($p=.05$) Between Pre- And Post-Test When The Three Group
Means Are Aggregated

	All Groups
AHI	.258
MHLC	
Internal Items	.112
Chance Items	.407
Powerful Others Items	.548
McGill	
Sensory	.861
Affective	.313
Evaluative	.008 *
Number Words Chosen	.149
Pain Rating Index	.389
Present Pain Index	.610
Beck	
Depression	.511
AIMS	
Mobility	.172
Physical Activity	.442
Dexterity	.023 *
Household Activity	.506
Social Activity	.031 *
Daily Living	.018 *
Pain	.597
Depression	.978
Anxiety	.224
Health Perceptions	.055
Arthritis Impact	.360
Total	.416

TABLE 4 (Cont')

Wilcoxon Matched-pairs Signed-ranks

Haemoglobin	.375	
White Blood Cell	.435	
Platelets	.027	*
Erythrocyte Sedimentation Rate	.321	
R F	.096	
Ritchie Articular Index	.135	
Pain VAS	.686	
Stiffness VAS	.696	p= .05

The results show that there were five items where the probability was above the $p=.05$ level and it was possible that some of these arose through chance. There would appear to be no evidence from these results that the group counselling had made a difference on the measures used. In any case with 31 results it would be expected that on the evidence of probability alone a number of positive results could be expected.

There seemed little possibility that positive results were going to be obtained from these measures. The final test used was the Kruskal-Wallis one-Way analysis of variance by ranks. The assumptions made in using this test were that the populations from which the samples were drawn have similar distributions, that the samples were drawn at random and that they are independent of each other. The results show whether the differences among the samples signify genuine population differences or whether they represent merely chance variations such as were to be expected among several random samples taken from the same population (Seigel, 1956). Table 5 gives the results.

TABLE 5

Kruskal-Wallis 1 Way ANOVA - Gives Probability ($p=.05$) For
The Results Of The Three Groups Aggregated On Pre- And Post-
Test Measures

	Jan	July
AHI	.395	.054
MHLC		
Internal Items	.903	.224
Chance Items	.779	.584
Powerful Others Items	.054	.007*
McGill		
Sensory	.147	.585
Affective	.057	.035*
Evaluative	.689	.346
Number Words Chosen	.045*	.373
Pain Rating Index	.079	.499
Present Pain Index	.197	.993
Beck		
Depression	.876	.957
AIMS		
Mobility	.047*	.066
Physical Activity	.057	.015*
Dexterity	.043*	.064
Household Activity	.478	.289
Social Activity	.605	.219
Daily Living	.004*	.008*
Pain	.156	.219
Depression	.302	.120
Anxiety	.920	.543
Health Perceptions	.348	.234
Arthritis Impact	.217	.714
Total	.437	.379

TABLE 5 (Cont')
Kruskal-Wallis One-Way Analysis of Variance (Cont')

Haemoglobin	.996	.768
White Blood Cell	.499	.742
Platelets	.126	.785
Erythrocyte Sedimentation Rate	.995	.902
R F	.350	.736
Ritchie Articular Index	.316	.523
Pain VAS	.335	.777
Stiffness VAS	.047*	.672

p=.05

There were no indications from these results that the measures have shown any differences over the various tests. Each test has shown a number of significant results but they in turn could be the subject of chance. The conclusions from these results was that the group counselling had not made any difference to the patients over the measures used.

It has already been mentioned that the group sizes were small and it was possible that differences did exist between the groups that had not been shown by the measures because of small sample sizes. If differences did exist then they would have to be investigated using different methods. An analysis by observation of the results would discover if a trend could be detected.

Table 6 investigates the results to discover whether or not the groups moved in a similar way and a trend established. If group 1 and 2 were moving in a similar direction whilst the control group was moving in the opposite direction then it would give an indication that a trend was emerging.

TABLE 6

Shows Direction of Movement By Group On Pre- And Post-Test Measures

Mean Average Movement by Group

	Group 1	Group 2	Control
AHI	↑	↑	↓
MHLC			
Internal Items	↓	↑	↓
Chance Items	↓	↑	↑
Powerful Others Items	↑	↑	↑
McGill			
Sensory	↓	↓	↑
Affective	↓	*	↓
Evaluative	↓	↓	↓
Number Words Chosen	↓	↓	↓
Pain Rating Index	↓	↑	↓
Present Pain Index	*	↑	↓
Beck			
Depression	↑	↑	↑
AIMS			
Mobility	↑	↑	↑
Physical Activity	*	↓	↓
Dexterity	↑	↑	↑
Household Activity	↑	↓	↑
Social Activity	↓	↓	↓
Daily Living	↑	↑	↑
Pain	↓	↑	↓
Depression	↓	↑	↑
Anxiety	↓	↑	↑
Health Perceptions	*	↓	↓
Arthritis Impact	↑	↓	*
Total	↑	*	↑

TABLE 6 (Cont')

Mean Average by Group

Haemoglobin	↓	↓	↓
White Blood Cell	↓	↑	↓
Platelets	↑	↑	↑
E S R	↓	↑	↑
R F	↓	*	*
Ritchie Articular Index	↑	↑	↑
Pain VAS	↓	↓	↑
Stiffness VAS	↓	↑	↑

↑ = Up ↓ = Down * = Same

The symbols for Table 6 indicate that when the arrow was pointing upwards the group have moved in a desired direction and when the arrow was pointing down they have moved in the opposite direction. The result for the Arthritis Helplessness Index (AHI) show that Group 1 and Group 2 have both improved on this measure whilst the Control Group have got worse. This was the only item where this preferred movement took place. An analysis of the data does not reveal a trend.

These results were derived from the means of the groups. It was possible that a trend was hidden behind the means. One result could have skewed the mean disproportionately. It was possible that 9 members of the group moved in one direction but because the tenth's result was so massively weighted in the opposite direction the mean did not reflect the movement of the majority. Table 7 shows the number of group members who moved either up or down on a measure or stayed the same.

TABLE 7

Gives Number of Patients By Group Who Went Up, Down Or
Stayed The Same

	Group 1			Group 2			Control		
	Up	Down	Same	Up	Down	Same	Up	Down	Same
AHI	6	4	0	6	2	1	5	5	0
MHLC									
Internal Items	2	7	1	4	4	1	4	3	3
Chance Items	6	4	0	4	4	1	5	3	2
Powerful Other Item	4	5	1	5	3	1	7	2	1
McGill									
Sensory	3	6	1	3	3	3	3	7	0
Affective	4	6	0	0	6	3	2	5	3
Evaluative	3	7	0	3	5	1	3	4	3
Number Words Chosen	3	7	0	3	4	2	5	5	0
Pain Rating Index	3	6	1	3	2	4	3	6	1
Present Pain Index	2	2	6	5	5	0	1	2	6
Beck									
Depression	5	3	2	2	3	4	6	4	0
AIMS									
Mobility	4	3	3	3	3	3	5	2	3
Physical Activity	2	2	6	5	3	1	2	4	4
Dexterity	7	2	1	3	3	3	5	2	3
Household Activity	3	1	6	2	6	1	4	3	3
Social Activity	4	6	0	2	0	7	3	6	1
Daily Living	4	1	5	6	2	1	4	3	3
Pain	6	4	0	6	3	0	3	5	2
Depression	4	5	1	7	2	0	4	5	0
Anxiety	4	6	0	3	7	0	6	2	2
Health Perceptions	3	4	3	4	2	3	4	5	1
Arthritis Impact	5	3	2	6	3	0	5	3	2
Total	6	4	0	4	5	0	5	5	0

TABLE 7 (Cont')

Direction Patient's Score Moved By Group

	Group 1			Group 2			Control		
	Up	Down	Same	Up	Down	Same	Up	Down	Same
Haemoglobin	5	5	0	5	4	0	5	5	0
White Blood Cell	7	3	0	7	2	0	10	0	0
Platelets	7	3	0	7	2	0	6	3	1
E S R	6	4	0	5	3	1	6	2	2
Ritchie Articular	3	6	1	4	5	0	7	3	0
Pain VAS	6	4	0	6	3	0	4	5	1
Stiffness VAS	5	5	0	5	4	0	5	5	0

Table 7 shows that there was no massive movement in either direction. For each item the movement was spread evenly. Only for a few items did 7 group members move in one direction. There appears to be no generalised trend. One result was interesting and that is the white blood cell item for the control group. The whole group moved in the desired direction. This is of interest for two reasons: firstly, it was the only example where the whole group moved in the same direction; secondly, the result does not prove to be above the .05 level of significance. The Mann-Whitney U-Test, Wilcoxon Matched-Pairs Signed-Ranks Test or the Kruskal-Wallis Test do not show the results to be significant.

Section 2

DISCUSSION

The qualitative and quantitative results have been given above. Whilst the results do not corroborate each other they do not directly contradict. The qualitative results show that group counselling has been a therapeutic intervention for this group of patients. The quantitative results show that group counselling had made no difference to them. Whilst the quantitative results do not show that the group counselling has made a difference they do not show that it has adversely affected patients. The two differing results have to be examined and reasons argued for selecting one set of results in preference to the other or a compromise reached between the two. The quantitative results will be investigated first.

Quantitative Results

The quantitative results confirm the findings of the previous studies (Henckle, 1975; Udelman, 1977; Schwartz et al., 1978; Udelman and Udelman, 1978; Kaplan and Kosin, 1981; Shearn and Fireman, 1985; Strauss et al., 1986). These papers also showed that the group counselling intervention had not made a difference on the measures used. There were no suggestions from these papers why no difference was shown. They did comment that the patients had enjoyed the group experience and the researchers were of the opinion that it had been beneficial. There was agreement that the quantitative measures did not show a change in patients, also that patients reported that they felt better. As these

studies all agree increased confidence can be put into their conclusions.

A number of reasons can be suggested as to why the quantitative measures show no change whilst the researchers report that the patients benefited. From the present study a number of reasons were apparent.

1) The patients did not enjoy completing the questionnaires. They found them tedious and tiresome. Patients had been advised by the researcher not to answer all the questionnaires at the same time but to spread them out. There was considerable variation in the length of the questionnaires. The Arthritis Helplessness Index and the Multidimensional Health Locus of Control questionnaires were one page and required patients to tick one statement from a range of statements. The Arthritis Impact Measurement Scale had 61 questions and was more extensive, the Beck Depression Inventory had 20 questions. The McGill Pain Questionnaire involved writing and marking drawings. The completion of the questionnaires was time consuming and despite spreading the task the questionnaires did not engage the patients' interest.

2) The patients commented that the questionnaires were not accurate in design. Often the questionnaires asked for one statement to be chosen from a range of possible statements. Patients were asked to choose the statement that came closest to their feelings. They proceeded as requested but commented that whilst they had selected the statement that most accurately represented their feelings from the range the statement was not an accurate reflection of how they actually felt.

3) Questionnaires in general were not designed to investigate individual cases. The object of the questionnaires was to permit a survey of a population. Comparability of response was the principle underlying factor in questionnaire design (Wilson, 1979). This approach was at the opposite end of a continuum which investigated patients as individuals.

4) The focus of the research was individuals in their singularity and uniqueness. During the group counselling the patients had been aware that it was as individuals they were valued and they had been encouraged to articulate their own feelings and opinions. Some of the changes that were noticed were too subtle to be picked up by questionnaires. For example Ida sat up and held eye to eye contact. This kind of change in individual behaviour would be difficult to be identified by questionnaires.

5) The standardised questionnaires used in the research have been piloted to ensure that they have satisfactory validity and reliability coefficients. Rheumatoid arthritis has already been described as a disease which was characterised by periods of exacerbation and remission. It would seem unlikely that a satisfactory reliability coefficient could be achieved if the patients physical condition was continually changing. If satisfactory reliability coefficients were achieved then it was doubtful that the questionnaires measured what they purported to measure.

6) The data extracted from the questionnaires was on an ordinal scale. This ordinal data was not very

powerful. There were limits to the extent to which it could be used. In the case of health it may not be appropriate because it cannot identify subtle changes. It has been argued previously that the relationship between an individual and their health was extremely complicated and it may be unrealistic to imagine that ordinal data can give accurate measurements of such a complex phenomenon.

7) The quantitative data was generated by a scientific research design which included a control group. The control group was a valuable safeguard against unrealistic claims for the group counselling intervention. The use of a control group originated from the physical and biological sciences where its use was perfectly legitimate. In a scientific research design which used a control group originating from the same tissue source or similar then the process has validity. This precise relationship did not exist in this research. The control group was compared with the counselled groups to see whether or not there were differences on the quantitative results. The extent to which this kind of control group ensures reliability and validity seems doubtful.

8) The actual constitution of an effective control group has been the subject of dispute. Different groups of patients have been used as control groups and they were discussed in Chapter 4. The implicit assumption for the control group was that nothing was going to affect it on the selected measures over a period of six months. It seems unrealistic to argue that patients' attitudes, as measured by the questionnaires were not going to change over such a lengthy period.

9) The patient's medical regimen may also have changed over a six month period. It has already been noted that patients continually alter their treatment (Huilgol et al., 1982). Also, a large number of drugs prescribed by consultants and doctors can be purchased in a pharmacy under different brand names (Pal, 1986). The assumption that patients cannot be their own therapeutic resource would appear to be naive and simplistic.

10) The statistical tests to measure accurately whether changes in groups of small numbers were significantly different were not available. The results that use small numbers were not very reliable. This was clearly demonstrated in the example of the white blood cells where the complete group moved in the same direction yet the result was not statistically significant. The accuracy of such a test must come into doubt unless larger samples are drawn. The Mann-Whitney U-Test does use sample sizes of < 8 but the reliability and validity of the results must inevitably be questionable.

Due to the nature of counselling it was not usual to work with group >10 . There was little chance of avoiding this problem. It was not feasible, for example, to put the results of five separate groups together to get a sample size of 50 because there could be no presumption that every group could be regarded as like. Each group developed a different climate and dynamics, and members left. It was apposite to recall that some medical research proceeded with single cases. Where new surgical techniques were being evaluated single cases were used and the evaluation was

eventually made as to whether the procedure should be incorporated into standard medical care.

11) None of the questionnaires had been specifically designed to measure the effects of group counselling. The questionnaires had come from other sources and had been designed for other reasons. The Arthritis Helplessness Index and the Arthritis Impact Measurement Scale were constructed for arthritic patients but the remainder were not. The group counselling intervention was largely unknown and therefore not possible to pre-test. The nature and power of the group was the actual intervention and could not be known in advance. The characteristics of each group would be unique and progress would be made in differing amounts and at differing rates. Accordingly there was no effective method of deciding what measures should be taken at the commencement of a group's life.

12) The validity of the questionnaire results was further questioned by the overlap in the sub-scales. Several of the questionnaires measured the same phenomenon. The McGill Pain Questionnaire measured pain and the AIMS and Visual Analogue Scales also measured it. The Mann-Whitney U-Test showed that a number of the measures were statistically significant but this was not corroborated in the other scores. Similarly the AIMS depression sub-scale was statistically significant but this was not corroborated in the Beck Depression Inventory result.

There was a lack of significant results for the clinical measures. Chapter 2 argued that there was a psychological component for rheumatoid arthritis. In which case it was possible that the psychological intervention of

group counselling may have affected the patient's physical condition. There was no evidence from the quantitative results to suggest that this was the case. Chapter 2 also presented evidence that argued that the clinical tests were unreliable and this may have contributed to the neutral results.

13) It had been noted in Chapter 5 when an account of the fieldwork was given that patients were taking fewer drugs and suffering more pain. If the clinical measures were to change then it could have been predicted that they would show a negative trend. The Visual Analogue Scale for pain and stiffness would have recorded increased pain and stiffness.

14) Chapter 5 noted that patients had said that whilst they were happy to participate in the research, imagining that it might do some good for others, they were sure that it would not help them. This attitude may have affected the responses they selected on the questionnaires. They may have selected neutral items which showed they felt no different.

A number of reservations regarding the quantitative results have been noted above. The attraction of using questionnaires was that they were simple to administer and allowed a considerable amount of data to be generated. As yet the quantitative data had failed to identify and monitor individual differences.

Qualitative Results

The qualitative results were based upon a

consensual set of statements which were negotiated with the patients. The statements were open to bias from a variety of different sources. It will be argued that the only bias that actually influenced the results was the prejudices of patients suffering from a chronic illness. The set of statements was divided into two sections, Section 1 dealt with the psychological concomitants of rheumatoid arthritis and Section 2 with an evaluation of group counselling as a therapeutic intervention for patients. These two sections will now be examined together as the points raised apply to both sections in the assessment of their validity, reliability and objectivity.

1) There was a discrepancy between the definition of the disease and the meaning it had for patients. One of the significant factors for patients were the periods of exacerbation and remission. This created insecurity and uncertainty which resulted in relationships being continually renegotiated, compromised and redefined. The qualitative results illuminated this aspect of patients' concern and the medical concept of the disease could not be regarded as adequate if it did not reflect the meaning that it had for patients.

2) It was discovered that pain was not the worst aspect of the disease. It was the sense of helplessness and the loss of control over life that created the greatest anxiety. Society had an ambiguous attitude to pain and it was not always perceived as a debilitating phenomena. The experience of pain was deliberately sought by some people. The experience of pain was a complicated issue that could not be adequately accounted for by the relatively simplistic

data generated by the quantitative results.

3) The patients felt that they could be psychologically strong whilst the disease was active and that it was more important to be psychologically strong than physically strong.

4) The importance that patients placed on having control over their lives was also evident in their changing attitude to drugs. Whilst drugs did bring a measure of pain relief they also brought side effects. These side effects such as dizziness, nausea and the sense of being ill made patients feel increasingly helpless and the patient preferred to suffer the pain. One of the main reasons for ascribing validity to the qualitative results was that they showed that patient s/behaviour had actually changed and if those changes were maintained it represents more than just a change in attitude or belief.

5) There were arguments as to why the set of statements may not have been accurate and they need to be examined. The opinions of the members of the groups were open to influence by the strongest members of the group. It is suggested that to repudiate the results on the basis of this argument would be erroneous. The consensual statements represented the opinions of the groups and peoples' opinions are influenced by others. Indeed that was the process of social behaviour. It was in recognition of this fact that the results have validity which can be contrasted against scientific research.

6) The 27 statements were given to the groups by the counsellors and the researcher. The groups may have

wished to please them and agreed with their findings or the groups may have felt that they were not qualified to comment on apparently important and academic matters. There are safeguards that this did not happen. As the group counselling had progressed the groups became very cohesive and they had taken on their group-as-a-whole identity. The climate of the groups was one of openness and support. Members felt free to self-disclose and this confidentiality was a characteristic of the groups. It was unlikely that the groups would have betrayed their own group-as-a-whole identity by agreeing to a set of statements which were not true.

7) The research represented a large commitment on the part of the group members. The fact that they were important to them was substantiated by the attendance and very low dropout rate. The patients were not going to keep coming to the group if they did not represent a reality that they could identify with. The groups were unlikely to agree just for the sake of pleasing the research team. The group-as-a-whole had become an actual source of identity for the patients which they were not likely to betray for the sake to the research team.

8) On many occasions the counsellors had presented thoughts, opinions and ideas for group discussion. The counsellors were used with being advised by the group and this method was normal to the group. The way in which they were approached at the end was no different from this method and it would be unlikely to be treated differently by the groups. The groups reacted in the same way as normal and freely offered their opinions and comments.

9) The qualitative results provided evidence that rheumatoid arthritis was a disease which had characteristics of both acute and chronic illness. This was an important illumination and laid the foundation for understanding how the disease affects patients. The stress and anxiety that patients felt arose from the ambiguity of two sickness roles. Patients were granted elements of the acute sickness role during a period of exacerbation which was then denied them when they went into remission.

10) The process of triangulation and respondent validation which were used in generating the qualitative results have been established as valid methods of conducting research. There is no suggestion that the method is problem free, but it is argued that it provides an important means of illuminating research material that is not readily available through traditional scientific methods.

SUMMARY

The qualitative results are not to be taken as generalisable and objective facts. New paradigm research should proceed as cautiously as scientific research. The statements exist as a tentative indication of wider truths. If this study was to be replicated and the statements confirmed by others then more weight could be put on their generalisability and objectivity.

The qualitative and quantitative results were presented in Section 1 and this section has evaluated them. From the discussion of the evidence it is evident that more weight should be given to the qualitative results. The

quantitative results still represent important data which will be incorporated into the conclusions which are given in Section 3.

Section 3

CONCLUSIONS

On the basis of the qualitative and quantitative results the following conclusions are presented.

1) The present definition of rheumatoid arthritis was unsatisfactory.

Chapter 1 investigated the concept of rheumatoid arthritis and its place in the classification of diseases. It concluded that the definition of the disease was not precise and the ambiguity was a possible source of stress and anxiety for the patients. This assertion has been corroborated by the patients. They experienced different approaches by both consultants and GP's and this resulted in increased stress and tension. It became clear that there was not a standard medical response to the disease and this caused confusion and uncertainty which was reflected in the approach to patients. Confirmation of this conclusion can be drawn from both the qualitative and quantitative results.

2) At present there are no psychological or clinical measures that adequately identified or monitored the disease process of rheumatoid arthritis.

The confusion and uncertainty associated with the

definition of rheumatoid arthritis may be reflected in the lack of accuracy in the psychological and clinical measures available. As the definition was imprecise so the investigative measures were also imprecise. This imprecision may explain why the quantitative results were neutral. The patients commented that the questionnaires showed little sign that the designer understood how the disease affected them or how they felt. There were inherent difficulties in designing measures for a disease that migrated between acute and chronic states and this was no doubt reflected in the neutral results. This conclusion is confirmed by both the qualitative and quantitative results.

3) There were three major theoretical basis for psychology which were psychoanalytic, behavioural and humanistic. Humanistic psychology was the most facilitative theoretical base for group counselling as a therapeutic intervention.

Chapter 3 argued that humanistic psychology was the most facilitative theoretical basis for the group counselling intervention. This theory has allowed the phenomenological experiences of patients to be illuminated. The complexity, irrationality and contradictions of patient's behaviour were adequately accommodated within the boundaries of this theory.

The humanistic psychological theory was more appropriate than behavioural or psychoanalytical theory. The theory permitted empirical data to be generated. The empirical data was examined with as much care, rigor and experimental verification as possible. It was acknowledged

that verification could not be achieved in the same way as with a scientific hypothesis (Needleman, 1978). The humanistic approach guaranteed the freedom to explore all areas of personality whereas psychoanalytic and behavioural psychology tended to concentrate upon dysfunctional aspects. The qualitative results provide confirmation for this conclusion.

4) The scientific research methodology does not adequately illuminate all aspects of patients' relationship with the disease.

Scientific research methodology could not adequately account for the impact that the disease had upon patients' lives. This arose because the scientific research model had some significant limitations when the subject of investigation was people. The major limitation concerned the control of variables. The traditional design introduced an independent variable which the experimenter controlled. The effect of the independent variable was measured by changes in the dependent variable. In this research the group counselling was the independent variable and the patients were the dependent variable. It would be unrealistic to argue that the only influence acting upon the patients over the six month period was the group counselling.

The scientific research methodology assessed the effectiveness of an intervention by the evaluation of data generated by pre- and post-test measures. The method of fixing the points for the pre- and post-test measures was arbitrary as far as the subjects were concerned. The points

were independent in the process of the patient's life. In fact all research investigated a process. New paradigm research tended to do it continuously whereas scientific research arbitrarily investigated fixed points in time. It would not have been possible to investigate the changing climate and dynamics of the groups without using new paradigm research methods. In the case of chronic illness it would be difficult to identify points in time because disease activity was a continuous process.

The existence of a placebo effect was a paradox that was never satisfactorily explained by the scientific theories. The paradox was that whilst scientific theories did not accept that there was a psychological component in disease they actually controlled for it. In some instances the placebo treatment was very powerful and in the case of chronic illness it was a therapeutic factor that deserved serious consideration.

Confirmation for the second conclusion can be drawn from both the qualitative and quantitative results.

5) The new paradigm research methodology was a satisfactory method of generating qualitative results which gave an accurate evaluation of the research.

The different research designs were discussed in Chapter 4. The chapter argued that both scientific and new paradigm research designs should be incorporated so that their strengths could complement each other. From the quantitative and qualitative results it would appear that the new paradigm research methodology was more effective. The weaknesses of the new paradigm research methodology such

as its subjectivity were compensated for by the process of triangulation and respondent validation. A reliable and valid set of qualitative results were produced.

6) Group counselling was an effective method of illuminating the psychological concomitants associated with rheumatoid arthritis.

The psychological concomitants associated with the disease were caused by the erosion of self-concept and self-esteem. This erosion was a consequence of continual role negotiation, role compromise and role redefinition that the migration between an acute and chronic illness caused. The erosion of self-concept and self-esteem resulted in stress and anxiety for the patients. It was clear from the qualitative results that the patient's physical condition was not the main cause. The qualitative results had increased understanding of the psychological concomitants. Chapter 2 described the psychological aspects connected with the disease and had noted that the scientific theory largely ignored this area. The previous research based upon scientific methodology had not illuminated the psychological concomitants but the new paradigm research methodology had. The qualitative results confirm this conclusion.

7) Group counselling was a psychologically therapeutic intervention for patients with rheumatoid arthritis.

Chapter 5 showed that group counselling was a

psychologically therapeutic intervention for this group of patients. The patients were sceptical at the beginning. This scepticism resulted, in part, from the scientific practice of medicine which emphasised physical symptoms. This belief system was communicated to patients. Patients believed they had a somatic condition and any psychological problems were not directly associated with it. This belief prejudiced the patients and caused the group counselling to start from a disadvantaged position. Over the course of the six months patients changed their beliefs and opinions and began to appreciate that group counselling could be a therapeutic intervention for them. The qualitative results support this conclusion.

8) Group counselling made no difference to the physical condition of patients with rheumatoid arthritis.

Chapter 2 discussed the psychological concomitants of the disease and noted that they might directly affect the physical condition of the patients. This evaluation of the group counselling has not found any evidence that the patients' physical condition has been affected by the intervention on either the qualitative or quantitative results. Some of the patients suffered more pain at the end of the six month period. This was a consequence of the patients deciding to reduce or stop their analgesics or non-steroidal anti-inflammatory drugs. There was however, no correlation between physical and psychological condition of the patients. Both the qualitative and quantitative results confirm this conclusion.

9) Rheumatoid arthritis was a disease that was characterised by aspects from both acute and chronic illness states.

It has already been noted that patients continually experience role negotiation, role compromise and role redefinition. This was a consequence of the disease process when patients could experience periods of exacerbation or remission. When they had a period of exacerbation they had increased disease activity from which they could expect to improve and this was a characteristic of acute illness. During those periods they were expected to adopt the sick role. Conversely, when patients experienced a period of remission they were expected to manage as best they could and adopt the role of the chronically sick person. The migration between these two roles increases the impact of the psychological concomitants. This conclusion suggests that revision of the definition of acute and chronic illnesses could help this group of patients. The qualitative results confirm this conclusion.

10) The central focus for the medical profession were the economic and political aspects of health.

The central focus for the consultants and GP's was the economic and political aspects of health. The consultants and GP's were constrained by the economic and political factors that controlled the government of the NHS. Economically, the system was concerned with factors like the numbers and flow of patients. Politically, it was concerned with factors like medical research and technology which

promoted the Rheumatology Department as a centre of authority and excellence. These two priorities curtailed the opportunities of responding to the patients as individuals. The patients accepted that they were a part of a larger bureaucratic system. The consultants and GP's were only concerned with their specific section of the NHS budget. There were many alternative courses of actions that patients took regarding their own health, including buying medicines at a pharmacy, trying alternative remedies, experimenting with diet and trying to cope without medication. They were permitted to pursue these courses of action so long as they did not interfere with the economic and political priorities of the consultants and GP's. The qualitative results support this conclusion.

Finally, it is comforting to appreciate that these conclusions were pre-empted over two centuries ago when Elizabeth Montagu wrote:

'I have swallowed the weight of an Apothecary in medicine and what I am the better for it, except more patient and less credulous, I know not. I have learnt to bear my infirmities and not to trust to the skills of Physicians for curing them. I endeavour to drink deeply of philosophy, and to be wise when I cannot be glad, content with what cannot be mended and patient where there can be no redress. The mighty can do no more, and the wise seldom as much.'

Section 4

RECOMMENDATIONS

The following recommendations are made. These recommendations are intended to be implemented in the existing clinical setting. They are divided into two sections. Section 1 deals with the implementation of counselling specifically for patients suffering from rheumatoid arthritis. Section 2 deals with recommendations concerning counselling in the wider context of clinical settings.

Section 1

1) Group counselling should be available as a therapy for patients suffering from rheumatoid arthritis and it should be available from the point of initial diagnosis.

2) Patients should be allowed to self select irrespective of any additional treatment they may be receiving. The patients who self select should be studied to determine whether instruments can be developed to accurately predict who would benefit from this form of therapy.

The patients who do not self select should be studied to determine whether they have common characteristics and whether the counselled patients arise from a biased sample.

3) The primary form of counselling available should be group counselling. The information exchange

section of the counselling process should be carefully monitored to determine its effectiveness in the therapeutic process.

4) The secondary form of counselling available should be individual counselling. It should be available for three specific reasons. Firstly, for patients whose social skills suggest that they would experience unnecessary stress and anxiety if initially placed in a group counselling situation, but that they should transfer at the appropriate maturational point. Secondly, in the interim period when sufficient numbers of patients are not available to start a new group. Thirdly, for patients who drop out of the group counselling.

5) The optimum number of patients in a group would appear to be 10, but due consideration be given to varying that number. The groups should be closed and members who drop out should be followed up to discover the reason.

6) A venue outside clinical settings should be arranged for group counselling. The groups counselled in that venue should be compared and contrasted with the groups counselled in clinical settings. An evaluation of the differences between the two should be made to determine the optimum setting.

7) The groups should be organised so that they are as heterogeneous as possible on the following criteria:

a) gender;

- b) duration of time since disease onset;
- c) degree of severity based upon classical, definite, probable and possible ARA criteria;
- d) age.

8) The groups should be organised so that they are as homogeneous as possible with regard to domicile. The groups should be encouraged to continue to meet upon termination of the group counselling. This would be facilitated by this administrative arrangement.

9) The duration of the group counselling should be six months. Groups should meet weekly for one hour. Variations of these intervals should be experimented with. Weekly meetings may be held until the information exchange stage had been passed then fortnightly meetings could be tried. These variations should be evaluated.

10) The primary theoretical orientation of the counselling should be based upon humanistic psychology. The group counsellors should be selected upon this basis. Techniques from other approaches and disciplines should be adopted into an eclectic approach which generates its own theory concerning group counselling for patients with a chronic illness.

11) Valid, reliable and appropriate instruments of evaluation should be developed. These instruments should evaluate the effectiveness of group counselling and should generate both qualitative and quantitative results.

Section 2

1) Group counselling should be evaluated as a therapeutic intervention for other chronic illnesses. Such evaluations should be compared and contrasted with the findings of the Rheumatology Department.

2) If the therapeutic effects of group counselling can be generalised to other chronic illnesses than an evaluation should be undertaken to determine the most effective place of group counselling within clinical settings. Such an evaluation should compare the benefits of group counsellors being attached to a variety of clinical settings or whether it would be preferable if they were located in their own separate clinic.

3) There are a number of concerned bodies that are not traditionally placed within hospitals but that carry out therapeutic functions. These bodies should be approached with a view to collaborative projects.

4) The medical and paramedical members of the Rheumatology Department should meet to determine a single approach that establishes the criteria for both diagnosis and treatment of patients suffering from rheumatoid arthritis.

5) The group counsellors should contribute to 4 by including appropriate psychological criteria which illuminates both the diagnosis and treatment of the disease.

6) The medical and paramedical members of the Rheumatology Department should participate in group counselling. The group should be limited to members of the department. Members should explore aspects of their personality with a view to improving the therapeutic relationship they have with patients.

7) Individual counselling should be available to the medical and paramedical members of the Rheumatology Department as a therapy for their personal or professional problems.

8) Individual and group counselling should be evaluated where possible for acute illnesses.

Appendices

Appendix A

November, 1985.

Dear

You are being invited to participate in a research project conducted by the University of Durham.

The project seeks to investigate how group counselling can help patients with rheumatoid arthritis.

Two groups, of 10 patients each are to be established. The first group will continue with their normal medical care and in addition will meet once a week for six months for approximately one hour for group counselling. The second group will just continue with their normal medical care. You will be assigned to either group on a random basis.

Agreement to participate in the project will entail the following:

1. That group counselling sessions will be recorded on closed circuit television but the recordings will be erased at the termination of the study unless patients give their consent that they can be retained.
2. That the research team can use the recordings in their findings.
3. That a number of psychological measures will be taken at the commencement and the termination of the study by patients completing a number of forms.
4. That a number of clinical measures will be taken ~~monthly~~ by the metrologist at the R.V.I.
5. That the research team may approach the members of either group after the termination of the study for clarification or additional information.
6. A guarantee of anonymity is given and no patient will be capable of being identified from any printed report.

Once patients have agreed to participate it is expected that they will continue to participate unless some untoward circumstances occur.

All information will be kept in confidence and trust according to human subjects experimental guidelines and the study has the agreement of the local Ethical Committee.

Yours sincerely,

D. Balmer,
Research Director.

Appendix B

Name

This questionnaire is designed to discover how you feel about certain aspects of your health. Each question consists of a number of statements. Would you read all of the statements and circle the NUMBER against the one that best describes how you feel at present. This is a measure of your personal opinions and obviously, there are no right or wrong answers.

Please answer these questions carefully, but do not spend too much time on any one question. As much as you can, try to answer each question independently. When making your choice, do not be influenced by your previous choices. It is important that you answer according to your actual feelings and not according to how you feel you should think or how you think we want you to feel.

- | | | | |
|----|--|-----|---|
| 1. | When you travel around your community, does someone have to assist you because of your health? | Yes | 1 |
| | | No | 2 |
| 2. | Are you able to use public transportation? | | |
| | No, because of my health | | 1 |
| | No, for some other reason | | 2 |
| | Yes, able to use public transportation | | 3 |
| 3. | Do you have to stay indoors most or all of the day because of your health? | Yes | 1 |
| | | No | 2 |
| 4. | Are you in bed or a chair for most or all of the day because of your health? | Yes | 1 |
| | | No | 2 |
| 5. | Does your health limit the kind of vigorous activities you can do such as running, lifting heavy objects or participating in strenuous sports? | Yes | 1 |
| | | No | 2 |
| 6. | Do you have any trouble either walking several blocks or climbing a few flights of stairs because of your health? | Yes | 1 |
| | | No | 2 |

- | | | | |
|-----|---|-----|---|
| 7. | Do you have trouble bending, lifting or stooping because of your health? | Yes | 1 |
| | | No | 2 |
| 8. | Do you have trouble either walking <u>one</u> block or climbing <u>one</u> flight of stairs because of your health? | Yes | 1 |
| | | No | 2 |
| 9. | Are you unable to walk unless you are assisted by another person or by a cane, crutches, artificial limbs, or braces? | Yes | 1 |
| | | No | 2 |
| 10. | Can you easily write with a pen or a pencil? | Yes | 1 |
| | | No | 2 |
| 11. | Can you easily button articles or clothing? | Yes | 1 |
| | | No | 2 |
| 12. | Can you easily turn a key in a lock? | Yes | 1 |
| | | No | 2 |
| 13. | Can you easily tie a pair of shoes? | Yes | 1 |
| | | No | 2 |
| 14. | Can you easily open a new jar of food? | Yes | 1 |
| | | No | 2 |
| 15. | If you had the necessary transportation:
<u>Could you go shopping for groceries or clothes ...</u> | | |
| | Without help (taking care of all shopping needs yourself) | | 1 |
| | With some help (need someone to go with you to help on all shopping trips) | | 2 |
| | Or are you completely unable to do any shopping | | 3 |

16. If you had a kitchen:
Could you prepare your own meals ...
- | | |
|--|---|
| Without help (plan and cook full meals yourself) | 1 |
| With some help (can prepare some things but unable to cook full meal yourself) | 2 |
| Or are you completely unable to prepare any meals | 3 |
17. If you had household tools and appliances (vacuum, mops, etc.):
Could you do your own housework ...
- | | |
|---|---|
| Without help (can clean floors, windows, refrigerator, etc.) | 1 |
| With some help (can do light housework, but need help with some heavy work) | 2 |
| Or are you completely unable to do any housework | 3 |
18. If you had laundry facilities (washer, dryer, etc.):
Could you do your own laundry ...
- | | |
|--|---|
| Without help (take care of all laundry yourself) | 1 |
| With some help (can do small items only) | 2 |
| Or are you completely unable to do any laundry | 3 |
19. If you had to take medicine:
Could you take all your own medicine ...
- | | |
|---|---|
| Without help (in the right does at the right time) | 1 |
| With some help (able to take medicine if someone prepares it for you and/or reminds you to take it) | 2 |
20. Do you handle your own money?
- | | |
|--|---|
| Without help (write cheques, pay bills, etc.) | 1 |
| With some help (day to day, but need help budgeting, etc.) | 2 |
| Or are you completely unable to handle any money | 3 |

21. If you had a telephone:
Would you be able to use it ...
- | | |
|---|---|
| Without help | 1 |
| With some help (can answer phone or dial operator
in an emergency, but need a special phone or help
in getting the number or dialing) | 2 |
| Or are you completely unable to use the telephone | 3 |
22. During the past month, about how often did you get
together socially with friends or relatives?
- | | |
|--------------------------------|---|
| Every day | 1 |
| Several days a week | 2 |
| About once a week | 3 |
| 2 or 3 times in the past month | 4 |
| Once in the past month | 5 |
| Not at all in the past month | 6 |
23. During the past month, about how often have you had
friends or relatives over to your home?
- | | |
|--------------------------------|---|
| Every day | 1 |
| Several days a week | 2 |
| About once a week | 3 |
| 2 or 3 times in the past month | 4 |
| Once in the past month | 5 |
| Not at all in the past month | 6 |
24. During the past month, how often have you visited
friends, or relatives at their homes?
- | | |
|------------------------------|---|
| Every day | 1 |
| Several days a week | 2 |
| About once a week | 3 |
| 2 or 3 times a week | 4 |
| Once in the past month | 5 |
| Not at all in the past month | 6 |

25. About how often were you on the telephone with close friends or relatives during the past month?
- | | |
|----------------------|---|
| Every day | 1 |
| Several times a week | 2 |
| About once a week | 3 |
| 2 or 3 times | 4 |
| Once | 5 |
| Not at all | 6 |
26. Has there been a change in the frequency or quality of your sexual relationships during the past month?
- | | |
|-----------------------|---|
| Change for the better | 1 |
| No change | 2 |
| Change for the worse | 3 |
27. When you bathe, either a sponge bath, tub or shower, how much help do you need?
- | | |
|---|---|
| No help at all | 1 |
| Help with getting some parts of your body, like back or leg | 2 |
| Help in bathing more than one part of your body | 3 |
28. How much help do you need in getting dressed?
- | | |
|-------------------------------|---|
| No help at all | 1 |
| Only need help in tying shoes | 2 |
| Need help in getting dressed | 3 |
29. How much help do you need to use the toilet?
- | | |
|---|---|
| No help at all | 1 |
| Some help in getting to or using the toilet | 2 |
| Not able to get to the bathroom at all | 3 |
30. How well are you able to move around?
- | | |
|--|---|
| Able to get in and out of bed or chairs without the help of another person | 1 |
| Need the help of another person to get in and out of bed or chair | 2 |
| Don't get out of bed | 3 |

31. How well are you able to control your bladder and bowel movements?
- | | |
|---------------------------------------|---|
| Complete control of bladder and bowel | 1 |
| Have occasional accidents | 2 |
| Do not have much control | 3 |
32. During the past month, how would you describe the arthritis pain you usually have?
- | | |
|-------------|---|
| Very severe | 1 |
| Severe | 2 |
| Moderate | 3 |
| Mild | 4 |
| Very mild | 5 |
| None | 6 |
33. During the past month how often have you had severe pain from your arthritis?
- | | |
|--------------|---|
| Always | 1 |
| Very often | 2 |
| Fairly often | 3 |
| Sometimes | 4 |
| Almost never | 5 |
| Never | 6 |
34. During the past month, how long has your morning stiffness usually lasted from the time you wake up?
- | | |
|-------------------------------|---|
| Over 4 hours | 1 |
| 2 - 4 hours | 2 |
| 1 - 2 hours | 3 |
| 30 minutes to an hour | 4 |
| Less than thirty minutes | 5 |
| Do not have morning stiffness | 6 |
35. During the past month, how often have you had pain in two or more joints at the same time?
- | | |
|--------------|---|
| Always | 1 |
| Very often | 2 |
| Fairly often | 3 |
| Sometimes | 4 |
| Almost never | 5 |
| Never | 6 |

36. During the past month, how often have you had to take medication for your arthritis?

- | | |
|--------------|---|
| Always | 1 |
| Very often | 2 |
| Fairly often | 3 |
| Sometimes | 4 |
| Almost never | 5 |
| Never | 6 |

37. During the past month, how much of the time have you enjoyed the things you do?

- | | |
|------------------------|---|
| All the time | 1 |
| Most of the time | 2 |
| A good bit of the time | 3 |
| Some of the time | 4 |
| A little of the time | 5 |
| None of the time | 6 |

38. During the past month, how much of the time have you felt tense or "high strung"?

- | | |
|------------------------|---|
| All of the time | 1 |
| Most of the time | 2 |
| A good bit of the time | 3 |
| Some of the time | 4 |
| A little of the time | 5 |
| None of the time | 6 |

39. How much have you been bothered by nervousness, or your "nerves" during the past month?

- | | |
|--|---|
| Extremely so, to the point where I could not take care of things | 1 |
| Very much bothered | 2 |
| Bothered quite a bit by nerves | 3 |
| Bothered some, enough to take notice | 4 |
| Bothered just a little bit by nerves | 5 |
| Not bothered at all by this | 6 |

40. How often during the past month, did you find yourself having difficulty trying to calm down?

Always	1
Very often	2
Fairly often	3
Sometimes	4
Almost never	5
Never	6

41. During the past month, how much of the time have you been in low or very low spirits?

All of the time	1
Most of the time	2
A good bit of the time	3
Some of the time	4
A little of the time	5
None of the time	6

42. How much of the time during the past month did you feel relaxed and free of tension?

All of the time	1
Most of the time	2
A good bit of the time	3
Some of the time	4
A little bit of the time	5
None of the time	6

43. How much of the time during the past month have you felt downhearted and sad?

All of the time	1
Most of the time	2
A good bit of the time	3
Some of the time	4
A little bit of the time	5
None of the time	6

44. How often during the past month did you feel that nothing turned out for you the way you wanted it to?

Always	1
Very often	2
Fairly often	3
Sometimes	4
Almost never	5
Never	6

45. How much of the time during the past month have you felt calm and peaceful?

All of the time	1
Most of the time	2
A good bit of the time	3
Some of the time	4
A little bit of the time	5
None of the time	6

46. During the past month, how often did you feel that others would be better off if you were dead?

Always	1
Very often	2
Fairly often	3
Sometimes	4
Almost never	5
Never	6

47. How much of the time during the past month were you able to relax without difficulty?

All of the time	1
Most of the time	2
A good bit of the time	3
Some of the time	4
A little of the time	5
None of the time	6

48. How often during the past month have you felt so down in the dumps that nothing could cheer you up?

Always	1
Very often	2
Fairly often	3
Sometimes	4
Almost never	5
Never	6

49. In general, would you say your health is excellent, good, fair or poor?

Excellent	1
Good	2
Fair	3
Poor	4

50. Thinking about the past month, how much of the time has your health kept you from doing the kinds of things that you should be able to do?

All of the time	1
Most of the time	2
Some of the time	3
None of the time	4

51. During the past month how active has your arthritis been?

Very active	1
Moderately active	2
Mildly active	3
Not at all active	4

52. Considering all the ways your arthritis affects you, mark (X) on the scale how well you are doing.

0	25	50	75	100
VERY WELL	WELL	FAIR	POOR	VERY POOR

NOTE: IN ANSWERING THE NEXT FOUR QUESTIONS, PLEASE PICK THE RESPONSE THAT BEST DESCRIBES HOW YOU FEEL ABOUT THE PRECEDING STATEMENT.

53. I seem to get sick a little easier than other people
- | | |
|------------------|---|
| Definitely true | 1 |
| Mostly true | 2 |
| Don't know | 3 |
| Mostly false | 4 |
| Definitely false | 5 |
54. I never worry about my health
- | | |
|------------------|---|
| Definitely true | 1 |
| Mostly true | 2 |
| Don't know | 3 |
| Mostly false | 4 |
| Definitely false | 5 |
55. My body seems to resist illness very well
- | | |
|------------------|---|
| Definitely true | 1 |
| Mostly true | 2 |
| Don't know | 3 |
| Mostly false | 4 |
| Definitely false | 5 |
56. When there is something going around, I usually catch it.
- | | |
|------------------|---|
| Definitely true | 1 |
| Mostly true | 2 |
| Don't know | 3 |
| Mostly false | 4 |
| Definitely false | 5 |
57. Do you take medicine every day for any problem other than your arthritis?
- | | |
|-----|---|
| Yes | 1 |
| No | 2 |
58. Did you see a doctor more than 3 times last year for any problem other than your arthritis?
- | | |
|-----|---|
| Yes | 1 |
| No | 2 |
59. How long have you had arthritis? _____ years

60. How many years have you been taking medicine for
arthritis? _____ years

61. Have you had any surgery because of your arthritis?

Total hip replacement	1
Total knee replacement	2
MCP anthroplasty	3
Other surgery	4
More than one joint replacement and/or surgery	5

Appendix C

This questionnaire is designed to discover how you feel about certain aspects of your health. Each question is a brief statement with which you may agree or disagree. Beside each question is a scale which ranges from "strongly disagree" to "strongly agree". For each question we would like you to put a 'X' in the box which most accurately stands for how you feel. Please make sure that you put an answer for each question, but only use one box. This is a measure of your personal opinions and obviously, there are no right or wrong answers.

Please answer these questions carefully, but do not spend too much time on any one question. As much as you can, try to answer each question independently. When making your choice, do not be influenced by your previous choices. It is important that you answer according to your actual feelings and not according to how you feel you should think or how you think we want you to feel.

Name.....	Strongly Disagree	Disagree	Agree	Strongly Agree
1. Arthritis is controlling my life.				
2. Managing my arthritis is largely my own responsibility.				
3. I can reduce my pain by staying calm and relaxed.				
4. Too often, my pain just seems to hit me out of the blue.				
5. If I do all the right things, I can successfully manage my arthritis.				
6. I can do a lot of things myself to cope with my arthritis.				
7. When it comes to managing my arthritis I feel I can only do what my doctor tells me to do.				
8. When I manage my personal life well my arthritis does not flare up as much.				
9. I have considerable ability to control my pain.				
10. I would feel helpless if I couldn't rely on other people for help with my arthritis.				
11. Usually I can tell when my arthritis will flare up.				
12. No matter what I do, or how hard I try, I just can't seem to get relief from my pain.				
13. I am coping effectively with my arthritis.				
14. It seems as though fate and other factors beyond my control affect my arthritis.				
15. I want to learn as much as I can about arthritis.				

Appendix D

MHLC Form B

This is a questionnaire designed to determine the way in which different people view certain important health-related issues. Each item is a belief statement with which you may agree or disagree. Beside each statement is a scale which ranges from strongly disagree (1) to strongly agree (6). For each item we would like you to circle the number that represents the extent to which you disagree or agree with the statement. The more strongly you agree with a statement, then the higher will be the number you circle. The more strongly you disagree with a statement, then the lower will be the number you circle. Please make sure that you answer every item and that you circle only one number per item. This is a measure of your personal beliefs; obviously, there are no right or wrong answers.

Please answer these items carefully, but do not spend too much time on any one item. As much as you can, try to respond to each item independently. When making your choice, do not be influenced by your previous choices. It is important that you respond according to your actual beliefs and not according to how you feel you should believe or how you think we want you to believe.

	Strongly Disagree	Moderately Disagree	Slightly Disagree	Slightly Agree	Moderately Agree	Strongly Agree
1. If I become sick, I have the power to make myself well again.	1	2	3	4	5	6
2. Often I feel that no matter what I do, if I am going to get sick, I will get sick.	1	2	3	4	5	6
3. If I see an excellent doctor regularly, I am less likely to have health problems.	1	2	3	4	5	6
4. It seems that my health is greatly influenced by accidental happenings.	1	2	3	4	5	6
5. I can only maintain my health by consulting health professionals.	1	2	3	4	5	6
6. I am directly responsible for my health.	1	2	3	4	5	6
7. Other people play a big part in whether I stay healthy or become sick.	1	2	3	4	5	6
8. Whatever goes wrong with my health is my own fault.	1	2	3	4	5	6
9. When I am sick, I just have to let nature run its course.	1	2	3	4	5	6
10. Health professionals keep me healthy.	1	2	3	4	5	6
11. When I stay healthy, I'm just plain lucky.	1	2	3	4	5	6
12. My physical well-being depends on how well I take care of myself.	1	2	3	4	5	6
13. When I feel ill, I know it is because I have not been taking care of myself properly.	1	2	3	4	5	6
14. The type of care I receive from other people is what is responsible for how well I recover from an illness.	1	2	3	4	5	6
15. Even when I take care of myself, it's easy to get sick.	1	2	3	4	5	6
16. When I become ill, it's a matter of fate.	1	2	3	4	5	6
17. I can pretty much stay healthy by taking good care of myself.	1	2	3	4	5	6
18. Following doctor's orders to the letter is the best way for me to stay healthy.	1	2	3	4	5	6

Name _____

This questionnaire is designed to discover how you feel about certain aspects of your health. Each question consists of a number of statements. Would you read all of the statements and circle the letter against the one that best describes how you feel at present. This is a measure of your personal opinions and obviously, there are no right or wrong answers.

Please answers these questions carefully, but do not spend too much time on any one question. As much as you can, try to answer each question independently. When making your choice, do not be influenced by your previous choices. It is important that you answer according to your actual feelings and not according to how you feel you should think or how you think we want you to feel.

Question 1.

- a I do not feel sad.
- b I feel blue or sad.
- c I am blue or sad all the time and I can't snap out of it.
- d I am so sad or unhappy that it is very painful.
- e I am so sad or unhappy that I can't stand it.

Question 2.

- a I am not particularly pessimistic or discouraged about the future.
- b I feel discouraged about the future.
- c I feel I have nothing to look forward to

- d I feel that I won't ever get over my troubles.
- e I feel that the future is hopeless and things cannot improve.

Question 3.

- a I do not feel like a failure.
- b I feel I have failed more than the average person.
- c I feel I have accomplished very little that is worthwhile or that means anything.
- d As I look back on my life all I can see is a lot of failures.
- e I feel I am a complete failure as a person.

Question 4.

- a I am not particularly dissatisfied.
- b I feel bored most of the time.
- c I don't enjoy things the way I used to.
- d I don't get satisfaction out of anything any more.
- e I am dissatisfied with everything.

Question 5.

- a I don't feel particularly guilty.
- b I feel bad or unworthy a good part of the time.
- c I feel quite guilty.
- d I feel bad or unworthy practically all the time now.
- e I feel as though I am very bad or worthless.

Question 6.

- a I don't feel I am being punished.
- b I have a feeling that something bad may happen to me.
- c I feel I am being punished or will be punished.
- d I feel I deserve to be punished.
- e I want to be punished.

Question 7.

- a I don't feel disappointed in myself.
- b I am disappointed in myself.
- c I don't like myself.
- d I am disgusted with myself.
- e I hate myself.

Question 8.

- a I don't feel I am any worse than anybody else.
- b I am very critical of myself for my weaknesses or mistakes.
- c I blame myself for everything that goes wrong.
- d I feel I have my bad faults.

Question 9.

- a I don't have any thoughts of harming myself.
- b I have thoughts of harming myself but would not carry them out.
- c I feel I would be better off dead.
- d I have definite plans about committing suicide.
- e I feel my family would be better off if I were dead.

f I would kill myself if I could.

Question 10.

- a I don't cry any more than usual.
- b I cry more now than I used to.
- c I cry all the time now. I can't stop it.
- d I used to be able to cry but now I can't cry at all even though I want to.

Question 11.

- a I am no more irritated now than I ever am.
- b I get annoyed or irritated more easily than I used to.
- c I feel irritated all the time.
- d I don't get irritated at all at the things that used to irritate me.

Question 12.

- a I have not lost interest in other people.
- b I am less interested in other people now than I used to be.
- c I have lost most of my interests in other people and have little feeling for them.

Question 13.

- a I make decisions about as well as ever I did.
- b I am less sure of myself now and try to put off making decisions.
- c I can't make decisions any more without help.

- d I can't make any decisions at all any more.

Question 14.

- a I don't feel I look any worse than I used to.
- b I am worried that I am looking old or unattractive.
- c I feel that there are permanent changes in my appearance and they make me look unattractive.
- d I feel that I am ugly or repulsive looking.

Question 15.

- a I can work about as well as before.
- b It takes extra effort to get started at doing something.
- c I don't work as well as I used to.
- d I have to push myself very hard to do anything.
- e I can't do any work at all.

Question 16.

- a I can sleep as well as usual.
- b I wake up more tired in the morning than I used to.
- c I wake up 1-2 hours earlier than usual and I find it hard to get back to sleep.
- d I wake up early every day and can't get more than 5 hours sleep.

Question 16.

- a I don't get any more tired than usual.
- b I get tired more easily than I used to.
- c I get tired from doing anything.

- d I get too tired to do anything.

Question 17.

- a My appetite is no worse than usual.
- b My appetite is not as good as it used to be.
- c My appetite is much worse now.
- d I have no appetite at all any more.

Question 18.

- a I haven't lost much weight, if any lately.
- b I have lost more than 5 pounds.
- c I have lost more than 10 pounds.
- d I have lost more than 15 pounds.

Question 19.

- a I am no more concerned about my health than usual.
- b I am concerned about aches and pains or upset stomach or constipation or other unpleasant feeling in my body.
- c I am so concerned with how I feel or what I feel that it's hard to think of much else
- d I am completely absorbed in what I feel.

Question 20.

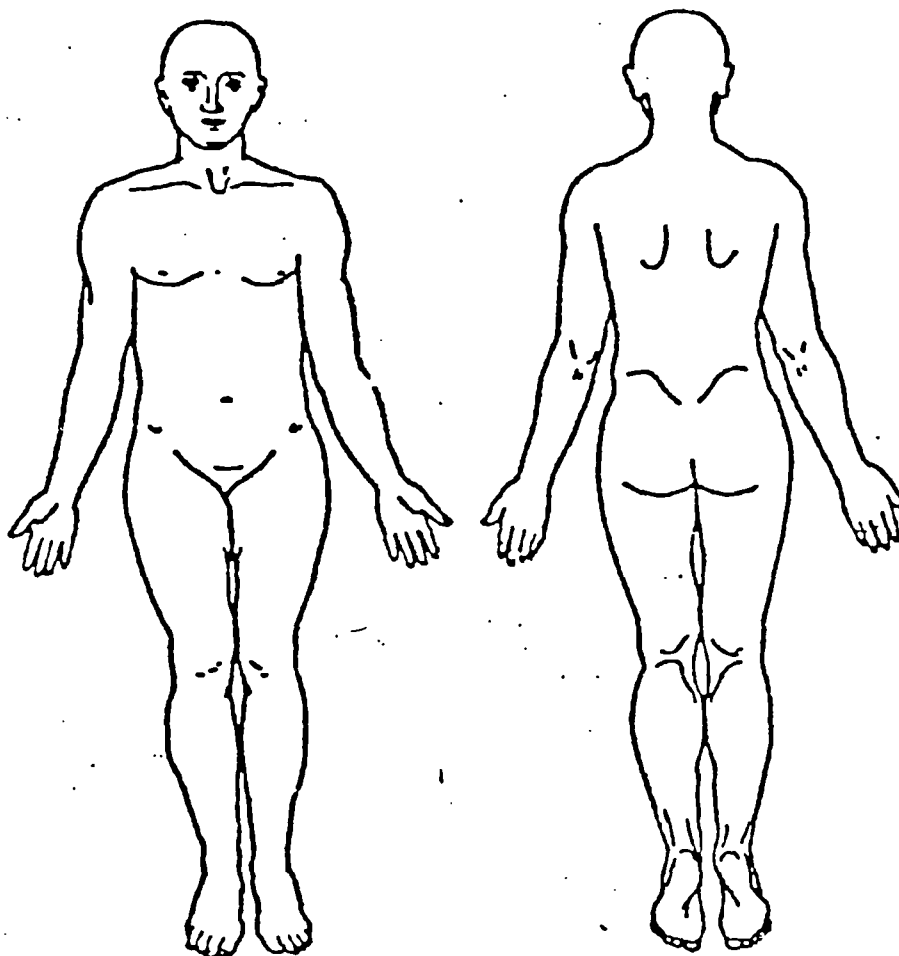
- a I have not noticed any recent change in my interest in sex.
- b I am less interested in sex than I used to be.
- c I am much less interested in sex now.
- d I have lost interest in sex completely.

Appendix F

Name _____

Part 1

Please mark on the drawing below, the areas where you feel pain. Put E if external, or I if internal, near the areas which you mark. Put EI if both external and internal.



Part 2 What Does Your Pain Feel Like?

Some of the words below describe your present pain. Circle ONLY those words that best describe it. Leave out any category that is not suitable. Use only a single word in each appropriate category - the one that applies best.

- | | | | |
|---|--|---|--|
| <p>1</p> <p>Flickering
Quivering
Pulsing
Throbbing
Beating
Pounding</p> | <p>2</p> <p>Jumping
Flashing
Shooting</p> | <p>3</p> <p>Pricking
Boring
Drilling
Stabbing
Lancinating</p> | <p>4</p> <p>Sharp
Cutting
Lacerating</p> |
| <p>5</p> <p>Pinching
Pressing
Gnawing
Cramping
Crushing</p> | <p>6</p> <p>Tugging
Pulling
Wrenching</p> | <p>7</p> <p>Hot
Burning
Scalding
Searing</p> | <p>8</p> <p>Tingling
Itchy
Smarting
Stinging</p> |
| <p>9</p> <p>Dull
Sore
Hurting
Aching
Heavy</p> | <p>10</p> <p>Tender
Taut
Rasping
Splitting</p> | <p>11</p> <p>Tiring
Exhausting</p> | <p>12</p> <p>Sickening
Suffocating</p> |
| <p>13</p> <p>Fearful
Frightful
Terrifying</p> | <p>14</p> <p>Punishing
Gruelling
Cruel
Vicious
Killing</p> | <p>15</p> <p>Wretched
Blinding</p> | <p>16</p> <p>Annoying
Troublesome
Miserable
Intense
Unbearable</p> |
| <p>17</p> <p>Spreading
Radiating
Penetrating
Piercing</p> | <p>18</p> <p>Tight
Numb
Drawing
Squeezing
Tearing</p> | <p>19</p> <p>Cool
Cold
Freezing</p> | <p>20</p> <p>Nagging
Nauseating
Agonizing
Dreadful</p> |

Part 3 How Does Your Pain Change With Time?

1 Which word or words would you use to describe the pattern of your pain?

1	2	3
Continuous	Rhythmic	Brief
Steady	Periodic	Momentary
Constant	Intermittent	Transient

2 What kind of things relieve your pain?

3 What kind of things increase your pain?

Part 4 How Strong Is Your Pain?

People agree that the following 5 words represent pain of increasing intensity.
They are:

1	2	3	4	5
Mild	Discomforting	Distressing	Horrible	Excruciating

To answer each question below, write the number of the most appropriate word in the space beside the questions.

- | | |
|---|-------|
| 1 Which word describes your pain right now? | _____ |
| 2 Which word describes it at its worst? | _____ |
| 3 Which word describes it when it is least? | _____ |
| 4 Which word describes the worst toothache you ever had? | _____ |
| 5 Which word describes the worst headache you ever had? | _____ |
| 6 Which word describes the worst stomach-ache you ever had? | _____ |

G

Appendix G

1 October 1985

Mr. D. Balmer
Flat D
38 Old Elvet
Durham

Dear Mr. Balmer

I was contacted this afternoon by Professor Farmer who required further information regarding a submission which was to be submitted to the Ethical Committee today. Since I had no prior knowledge of this I was unable to provide any further information and this is a most unsatisfactory state of affairs.

I gather that the proposal was inadequately documented and clumsily presented.

In future please ensure that in any collaborative work with us you present all relevant documents to us prior to despatch.

Please make an appointment to come and see me.

Yours sincerely

Carson Dick

cc Professor Farmer, Chairman, Ethical Committee
Professor Coffield, School of Education, Durham University
Dr. I. Griffiths, Dept. Rheumatology, RVI

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